

JACQUELYN WHITE
2/12/2020

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
SHREVEPORT DIVISION

AKEEM HENDERSON and JENNIFER
ALEXANDER, INDIVIDUALLY AND
AS ADMINISTRATRIX OF THE
SUCCESSION OF A.H.

CIVIL ACTION NO. 5:19-CV-00163

VERSUS

JUDGE ELIZABETH E. FOOTE

MAGISTRATE JUDGE MARK L. HORNSBY

WILLIS-KNIGHTON MEDICAL
CENTER d/b/a WILLIS KNIGHTON
SOUTH HOSPITAL

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DEPOSITION OF

JACQUELYN WHITE, M.D.

February 12, 2020

* * * * *

Taken at:

Health Hut
310 West Mississippi Avenue
Ruston, Louisiana

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Reported by: Janet McBride
Certified Court Reporter
Certificate No. 27006

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ADMINISTRATRIX OF THE SUCCESSION OF A.H.:

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I N D E X

EXAMINATION:

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MR. BANKS	5
MR. ROBISON.	None
MR. PUGH	None

EXHIBITS:

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S T I P U L A T I O N S

It is stipulated and agreed among counsel that the deposition of JACQUELYN WHITE, M.D., is taken by plaintiffs, AKEEM HENDERSON AND JENNIFER ALEXANDER, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE SUCCESSION OF A.H., pursuant to Notice, and may be used for all purposes permitted by the Federal Code of Civil Procedure. All objections except as to the form of the question and responsiveness of the answer are reserved until such time as the deposition is offered and introduced into evidence. The deponent elected to read and sign her deposition.

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* * * * *

JACQUELYN WHITE, M.D., after having been first duly sworn,
testified as follows:

* * * * *

MR. BANKS: Dr. White, may name is Sedric
Banks. We just met here before the deposition.
I represent the plaintiffs in this case. This
is my son, Hutton Banks, who is co-counsel with
me in this case.

EXAMINATION BY MR. BANKS

Q. Will you state your name for the record, please?

A. Jacquelyn Kibodeaux White.

Q. And, Dr. White, I understand you are an emergency
medicine physician?

A. Yes, sir.

Q. And when did you become licensed as a physician?

A. I finished my residency in 1995 and have practiced
emergency medicine since then.

Q. And where do you practice?

A. I practice at Northern Louisiana Medical Center, ER,
here in Ruston as well as Glenwood in West Monroe.

Q. And you were retained in this case by whom?

A. Mr. Bob Robison.

Q. And that was the initial contact was coming from Mr.
Robison?

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1 A. Yes, sir.

2 Q. And when was that?

3 A. About a month ago.

4 Q. And I'm not looking for exact dates. I'm just
5 trying to piece together some information. Okay. And what
6 were you asked to do?

7 A. To review a case for him.

8 Q. And what were you looking for in your review?

9 A. To see if there was an EMTALA violation, to evaluate
10 a case to see if there was an EMTALA violation.

11 Q. I understand you testified in a couple of different
12 cases in court.

13 A. I have. Yes, sir.

14 Q. Did either one of these cases involve EMTALA?

15 A. No, sir.

16 Q. Out of curiosity, what were those cases about?

17 A. One was about a lady that had a stroke and was sent
18 home initially and then came back with her symptoms, and
19 then was over that. Another one was about a patient that
20 had a heart attack or came in with chest pain, shortness of
21 breath, was discharged. And then the third-- I think I've
22 had two or three. And then the other one was chest pain,
23 he came in and had a heart attack, but it was the timing of
24 the cardiologist involved and going to the cath lab.

25 Q. And who were you retained by, the plaintiff or the

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1 defendant in those cases?

2 A. The defendant in all of them. Yes, sir.

3 Q. Have you ever testified for a plaintiff?

4 A. I've not testified for one. No, sir.

5 Q. How do you get contacted or connected, I guess is a
6 better word, with the legal world? Do you advertise or--

7 A. No, sir. I do not advertise. Those previous ones
8 were from-- There was a nurse in Jonesboro that did a lot
9 of medical reviews, and my name was given to her so I've
10 looked at several charts for her. And then those two cases
11 that came from Florida were from a colleague of hers that
12 needed an emergency medicine physician to review. The one
13 in Opelousas, I was on the medical review panel and so I
14 was not asked, but told that I needed to come and do a
15 deposition on why we--why we--how we chose our disposition
16 of that case.

17 Q. You mentioned a medical review panels, and I think I
18 read that in your report that you had done several.

19 A. Yes, sir.

20 Q. And I'm not looking for exact numbers, but when you
21 say several, what are we talking about?

22 A. I'd probably say at least twelve to fourteen.

23 Q. Did any of those involve EMTALA?

24 A. They did not.

25 Q. Again, out of curiosity, did any of those cases

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1 where you appeared or participated on the medical review
2 panel, did any of those cases result in a positive finding
3 for medical negligence?

4 A. Yes, sir.

5 Q. Okay. You say in this case that you reviewed some
6 hospital records.

7 A. Yes, sir.

8 Q. All right. And if I've got it right, your report
9 says that there were two sets of-- Well, actually, let me
10 just get to the report. I'm looking at your report dated
11 January the 24th of 2020. And it says that, a, b, c, d
12 lists the information that you reviewed. And if I have it
13 right, you reviewed the Willis-Knighton South emergency
14 room record.

15 A. Yes, sir.

16 Q. For February the 10th.

17 A. Yes, sir.

18 Q. And you reviewed the Willis-Knighton Bossier
19 emergency room records for February the 10th. And then you
20 reviewed the copy of the complaint filed by the plaintiffs.
21 Do you remember reading the plaintiff complaint?

22 A. Yes, sir. I haven't read it recently but I did read
23 it initially.

24 Q. Anything jump out at you as being inaccurate or
25 untrue in that complaint?

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1 A. Not that I can recall.

2 Q. And then I see the subpart D there that you reviewed
3 a copy of a complete Willis-Knighton South record on A.H.
4 What did you think the complete Willis-Knighton South
5 record was?

6 A. Well, I asked for if she--if they had any previous
7 ER records so that I could look at them. I don't know if
8 it was complete. I'm not sure where the child was born,
9 but those records that I received were from her ER visits
10 from about six months old, if I'm correct, up until the
11 time of this ER visit.

12 Q. And we've just, for the record and for clarity, you
13 understood and, today understand that initials A.H. relates
14 to a four-year-old, a female child?

15 A. Yes, sir.

16 Q. Okay.

17 (OFF RECORD COMMENTS)

18 Q. About how long after you received-- Well, I guess
19 maybe that's--I'm getting ahead of myself. How did you get
20 these records?

21 A. Email.

22 Q. And the email was from Mr. Robison?

23 A. Yes, sir.

24 Q. How long after you got the email and got the
25 records, was it before you wrote your January 24th report?

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1 A. I can tell you that I started looking at them on the
2 11th or 12th and probably wrote--this is my--the initial
3 report maybe was written on the 22nd, 23rd, so within that
4 time frame.

5 Q. Okay. And you say initial report, what did you do
6 with the initial report?

7 A. Well, I didn't-- I still have it. It wasn't in the
8 way that it needed to be legal. Probably this--the initial
9 report was my part from the--from letter D on, just my
10 saying, and so I--those things were--I needed to put--I
11 didn't put in the provided documents.

12 Q. Do you have a copy of your initial report?

13 A. I do not have it on me, but I'm sure on our email.

14 Q. Okay.

15 A. But I can get it for you, if you'd like.

16 Q. We'll pass that for right now and maybe come back to
17 later.

18 A. Yes, sir. Okay.

19 Q. I think you answered the question and I probably
20 lost the answer, but what did you think the complete
21 Willis-Knighton South record was?

22 A. Her ER visits as well as--

23 Q. Past visits?

24 A. Past visits. Yes, sir.

25 Q. What significance-- I'm sorry. I didn't mean to

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1 interrupt. What significance, if any, did you place on the
2 past visits?

3 A. When it was said in the plaintiff file that the
4 hospital knew the patient, because she had been there
5 before, I felt that I needed to look at those as well, if I
6 could give an accurate account of this ER visit. And if
7 it's accessible there, it's accessible to both the nurse
8 and the provider. So it's a matter of looking at her past
9 ER visits to see is there a pattern, had this happened, was
10 there something lost or missing. It gives a more complete
11 picture of a patient to see the past visits, and it's very
12 common to look at that when you're assessing a patient.

13 Q. Just generally, what did you find in those past
14 medical records?

15 A. That she had very frequent ER visits.

16 Q. And was it for a recurring problem or was it for
17 multiple problems?

18 A. It was for recurring problems, mostly related to
19 respiratory, cold, cough, fever. They were all related to
20 that. In fact, except one was a rash, and even on that
21 one, the child I think had an ear infection. So a lot of
22 it was related to respiratory.

23 Q. Would it be fair to say that other than the rash,
24 they were all related to respiratory?

25 A. Yes, sir.

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1 Q. Did you understand that this particular child, this
2 four-year-old child, was a premature baby?

3 A. Yes, sir.

4 Q. Is there any complications that you associate with a
5 premature baby?

6 A. I did not in this record. Other than showing that
7 she had prematurity, there was nothing that I found that
8 she had any continual--but I didn't see her records prior
9 to six months old, but I did not see any of that. She is a
10 child with asthma, is what I found from that.

11 Q. And did you find that asthma was really the cause of
12 her past emergency room visits?

13 A. Of a lot of her visits, yes, sir.

14 Q. Did you notice where she was hospitalized for
15 asthma?

16 A. Yes, sir.

17 Q. Did you notice the vital signs when she was
18 hospitalized?

19 A. I looked at all the records and I looked at some of
20 the vital signs. Yes, sir.

21 Q. What significance, if any, does the vital sign play
22 in examining a patient?

23 A. Vital signs are part of the picture when evaluating
24 the patient, just as-- You have a picture of multiple
25 things that you assess. Vital signs are part of that.

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1 There are several vital signs you look at, as well as your
2 examination, as well as your history of present illness.

3 It all plays a part. Yes, sir.

4 Q. So we're dealing with examination, vital signs and
5 what else is in the components that--

6 A. History.

7 Q. History. Okay. I noticed that in your report, that
8 you did not mention that you had reviewed the death
9 certificate. Did you--

10 A. I didn't. I do not remember seeing the death
11 certificate. No, sir.

12 Q. Did you review the autopsy?

13 A. I did not. No, sir.

14 Q. Did you review the protocol for the hospital as far
15 as administering oxygen?

16 A. No, sir.

17 Q. Did you review the interpretative guidelines for
18 EMTALA?

19 A. I read over some EMTALA. I'm not sure if I read the
20 complete EMTALA, but I did look at some things about
21 EMTALA.

22 Q. Tell me what you recall about reading the EMTALA
23 that you--

24 A. May I look at my notes while I'm telling you that?

25 Q. Yes. You may. Please do.

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1 A. Okay. EMTALA, to me, was--is something that we look
2 at that was written--and I mean, I've practiced medicine
3 for twenty-five years, and it's kind of known as the anti-
4 dumping law. EMTALA is to protect a person that they can
5 get treatment regardless of ability to pay and that we're
6 going to see them regardless of ability to pay and we're
7 not going to stop and wait on treatment until we get any
8 payment. And we're not going to transfer a patient because
9 of inability to pay. So I reviewed EMTALA to make sure
10 that I was--that is what I'm-- We do EMTALA training,
11 continuing education, with both our companies that we work
12 for, as well as the hospitals that we work for. And so
13 it's--I just looked over the anti-dumping law and the
14 different components of it because I know that was a huge
15 thing--part of this case.

16 Q. And tell me, if you will, how you saw EMTALA
17 correlating to this case.

18 A. Yes, sir. To be honest, I did not see a lot of
19 correlation because I think of EMTALA from a clinical point
20 as a patient being transferred, an inappropriate transfer.
21 Not an inappropriate discharge to home. So to be honest,
22 it was--it was different for me from the clinical side
23 because a transfer doesn't--in a--in a clinical mind, it
24 doesn't mean transfer to the house. It means transfer to
25 another facility.

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1 Q. Well, tell me how or if at all the discharge figured
2 into what you looked at.

3 A. So when I evaluated this case, I evaluated was the
4 patient appropriate--were they given a medical screening
5 exam, did they have an emergency medical condition, were
6 they given an exam, were they given appropriate treatment,
7 and were they inappropriately or appropriately discharged.
8 And so that's how I looked at the chart.

9 Q. And did you find that there was an emergency medical
10 condition?

11 A. There was an emergency medical condition. Yes, sir.

12 Q. And what was that condition?

13 A. Respiratory distress, an asthma exacerbation.

14 Q. Would it be fair to say that the primary focus and
15 goal of an emergency room physician treating such a patient
16 with respiratory distress, would that main focus be on
17 keeping that respiratory distress from becoming respiratory
18 failure?

19 A. I wouldn't say that's-- The primary goal is to
20 treat the patient and to stabilize them.

21 Q. To stabilize them.

22 A. Yes, sir.

23 Q. How would you know if a patient is stable?

24 A. Well, what's your definition of stable?

25 Q. That's what I don't know.

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1 A. Okay.

2 Q. I've been practicing law for forty-four years and I
3 never have figured that out.

4 A. Okay. I will tell you from an emergency medicine
5 physician,--

6 Q. Please.

7 A. --if they're stable enough to be discharged, or do I
8 feel the patient needs to be admitted. That's a primary
9 concern on anyone that's having any kind of emergency
10 medical condition is can they continue treatment at home or
11 do they need to continue treatment in the hospital. Have
12 you resolved it? Have you improved it? A patient doesn't
13 have to be back to baseline. Are they improved well enough
14 that they can continue the treatment at home? That's one
15 of our first things that we think of when we have someone
16 with an emergency medical condition.

17 Q. What is the baseline for this particular child?

18 A. A base-- Well, I--I don't know the baseline of a--
19 of this particular child. Was the child improved or did
20 the--did the provider feel like the patient was stable
21 enough to be discharged. It is-- According to the EMTALA
22 definition of within reasonable medical probability, and I
23 feel that this patient was, after reviewing the chart in
24 completeness.

25 Q. All right. If we're going to tell the jury here's

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1 the list that we want to go down, the list with each item
2 to determine whether or not this particular child was or
3 was not stable, what's on that list?

4 A. So how I looked at it to see-- There's--there's
5 several things.

6 Q. Okay.

7 A. From the treatment that the child was given, the
8 treatment that the child needed to improve, the nursing
9 assessment, the provider assessment, the re-assessments,
10 and how the patient did during the ER visit and did you
11 feel comfortable that the patient was in an environment
12 that they could continue upon discharge, a safe
13 environment, an appropriate environment.

14 Q. Okay. I understand you looked at all of those
15 things that you mentioned, but tell me where the vital
16 signs come in.

17 A. Okay. This patient, on this record, had two
18 different sets of vital signs, if I'm correct. You look at
19 the vital signs initially, they're part of the complete
20 picture, as I said earlier, and then you look at the trend.
21 She had another set of vital signs approximately an hour
22 and twenty minutes later. And then the patient was
23 discharged approximately forty-five minutes after that.
24 Vital signs are part of the picture. And each vital sign
25 represents something. I don't think that you can hang your

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1 hat on one vital sign or the other, but I think it's part
2 of the picture of the reassessment of the patient.

3 Q. Would you say that that's the most important part?

4 A. I wouldn't say it's the most important part.

5 Q. What would you think the most important part is?

6 A. I think it's a combinat-- I think the doctor
7 reassessing a patient is the most important part.

8 Q. The trends that you mentioned, what kind of trends
9 are you referring to?

10 A. Are the vital signs improving or are they worsening?
11 Are they changing? Are they the same? That's the trend
12 that I'm talking about. Yes, sir.

13 Q. Okay. Now, you understood that this particular
14 child with a history of asthma and breathing difficulties
15 woke up about 12:00 midnight wheezing and coughing on
16 February the 10th?

17 A. Yes, sir.

18 Q. Did you understand that the child was taken to the
19 emergency room at 1:50--I'm sorry, 2:04 in the morning?

20 A. Yes, sir. They presented at 1:54. Yes, sir.

21 Q. Okay. Now, if I'm right, there was some breathing
22 treatments administered immediately upon arrival. Did you
23 see that or did you understand that?

24 A. Yes, sir.

25 Q. Okay. Do you know whether or not the breathing

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1 treatments were administered before the vital signs or
2 after the vital signs?

3 A. Well, it looks like-- Going by the chart, the
4 breathing treatment is documented as starting
5 administration at 2:04. A breathing treatment takes
6 approximately ten to fifteen minutes, sometimes twenty
7 minutes, to be given. So it says at 2:04, the first set of
8 vital signs are put in at 2:05. But it looks like they
9 signed in at 1:54. So within ten to fifteen minutes. Now,
10 you have the nursing--the nursing vital signs that are done
11 at 2:05. So it looks like they were kind of in a
12 combination together.

13 Q. Do you feel like there was a sense of urgency in the
14 emergency room that night?

15 A. Yes, sir.

16 Q. And what was the emergency?

17 A. The emergency was that the child was wheezing and
18 having some difficulty breathing.

19 Q. Okay. The vital signs that were taken upon the
20 initial--the initial vital signs, were they normal or
21 abnormal?

22 A. The breathing was slightly increased. The
23 respiratory rate, the heart rate could be perceived as
24 normal. There's variable normals in a four-year-old child.
25 The pulse ox was a little low and the temperature was at

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1 99.3.

2 Q. Okay. Let's go over the pulse first.

3 A. Yes, sir.

4 Q. What was the pulse rate?

5 A. One fifty-six.

6 Q. Is that above average?

7 A. It is at the higher limits of normal. It can be
8 average. I think if you look at different pediatric,
9 they'll give you ranges of heart rates.

10 Q. And what did you think the range was for a four-
11 year-old?

12 A. That's probably a little bit high. It can be
13 average. When a child--when anyone arrives to the ER, you
14 can be anxious and nervous, but that is a little high. She
15 also received an Albuterol treatment at home before she
16 came, and Albuterol can also raise your heart rate a little
17 bit. So she did receive one treatment after they woke up,
18 according to the record.

19 Q. Okay. Did you understand that that one treatment
20 that she received at home sometime just shortly after
21 midnight wasn't working?

22 A. Yes, sir.

23 Q. And you understand it wasn't working so, therefore,
24 they brought this child to the emergency room?

25 A. Yes, sir.

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1 Q. Okay. Let's go to the respiratory rate on initial
2 taking of the vital signs. Is that average or normal or
3 high average or--

4 A. I will say the normal for a four-year-old is around
5 twenty-two to thirty-four. So it is barely elevated. Yes,
6 sir.

7 Q. Okay.

8 A. She was slightly tachypneic. It's a very common
9 thing with asthma exacerbations. Yes, sir.

10 Q. Tachypneic is what?

11 A. Breathing a little fast.

12 Q. And do you know why she was breathing fast? I mean,
13 the physiology of that.

14 A. Because she was--she was wheezing which is
15 congestion in the lungs which is having trouble getting the
16 oxygen in there because of the inflammation. So it causes
17 them to breathe a little faster.

18 Q. Now, the medication, Albuterol. Is that right?

19 A. Albuterol. Yes, sir.

20 Q. Albuterol. Okay. Thank you. You say that can
21 increase the--

22 A. It can--

23 Q. --heartbeat.

24 A. --slightly. Yes, sir.

25 Q. So you really, it's fair to say that upon entry in

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1 the emergency room, the physicians really didn't know what
2 was causing the high respiratory rate. Is that right?

3 A. I wouldn't say that they didn't know because I think
4 the parent presented as an asthma exacerbation. And when a
5 nurse does the initial part of the vital signs is listening
6 to the lungs. So I think they knew or had a good idea of
7 where it was coming from being the fact that they gave them
8 a treatment within ten to fifteen minutes.

9 Q. Is it fair to say that the Albuterol relaxes the
10 airways but it has no affect at all upon the inflammation?

11 A. Yes, sir. That is fair to say. It's a muscle--it's
12 a relaxant--it's an anti-inflammatory--kind of a little bit
13 of both, but it does relax the airways to open them up.

14 Q. Right.

15 A. Asthma causes inflammation and swelling of the lower
16 airways and so Albuterol helps to open that up. Yes, sir.

17 Q. Okay. With the initial treatment, did it involve
18 treating the inflammation?

19 A. The initial treatment did the inflammation mostly.
20 That is how you treat it initially. The child had a DuoNeb
21 which is a combination of Albuterol and ipratropium, which
22 both, in different ways, relax smooth muscle in the lungs
23 and then the second treatment was just Albuterol by itself.

24 Q. Okay. I think--

25 A. Yes, sir.

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1 Q. --you're ahead of me here, but I'm still staying
2 with this initial assessment of vital signs.

3 A. Yes, sir.

4 Q. Okay.

5 A. And the initial treatment was a DuoNeb.

6 Q. At what time was that?

7 A. At 2:04.

8 Q. 2:04. Okay.

9 A. Yes, sir.

10 Q. That's the DuoNeb that you referred to.

11 A. Uh-huh (yes).

12 Q. So is it fair to say that looking back at the
13 picture as it's developing, the Albuterol was not working
14 at home. She gets to the hospital some two hours later
15 after waking up, and additional medication is given.

16 A. Yes, sir.

17 Q. Now, let's go back to that vital signs again, the
18 initial entry of vital signs. Temperature was elevated or
19 normal?

20 A. That was normal.

21 Q. Okay. And let's go to the pulse oximeter. What
22 does that say?

23 A. Ninety-one percent.

24 Q. Okay. Tell me about the ninety-one percent. How
25 does an emergency room physician view that ninety-one

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1 percent?

2 A. In a child that's having trouble breathing, it tells
3 me that they're in need of some treatments as well as some
4 supplemental oxygen. So that patient was probably--and I
5 think it shows in the record--put on some supplemental
6 oxygen as well as given the DuoNeb treatment.

7 Q. Okay. How would you measure the ninety-one percent?

8 A. You measure it--you put a--it's a pulse ox that you
9 put on their finger and it's-- Most of the time, it stays
10 on the patient the entire ER visit or until they feel
11 pretty sure that they don't need it anymore. But most of
12 the time, it's on the entire visit.

13 Q. How would you know that you don't need it anymore?

14 A. The child's running around the room, pulling it off.
15 They're playful. They're active. And they've been at
16 ninety-nine, they've been at ninety-five, they've been at
17 whatever, you feel comfortable enough taking it off. It's
18 part of the whole picture.

19 Q. So would it be fair to say that you believe that the
20 oxygen level was monitored the entire time she was in the
21 emergency room?

22 A. That's how most patients are. There's no way to
23 tell from this record. You'd have to go to their facility
24 and see. Most facilities now have the monitor in the rooms
25 where it's continuous.

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1 Q. Okay. So the child comes in with breathing problems
2 and you measure the oxygen level. Is it important to get a
3 baseline before you start treating the child?

4 A. No, sir.

5 Q. You don't need a baseline?

6 A. If a child's in distress, you can look at them and
7 start the treatment. You don't hold up the treatment to
8 get a baseline. But putting them on the monitor at the
9 same time, you're kind of doing it all at the same time.
10 So I feel like that was put on at the same time the
11 treatment was ordered, the medicine was given, and the
12 nurse was putting in the vital signs.

13 Q. Ninety-one percent, is that average?

14 A. No, sir.

15 Q. What is the average for a four-year-old child?

16 A. Average for a four-year-old child is probably
17 ninety-six to a hundred.

18 Q. So would it be fair to say that these vital signs
19 upon entry were not normal?

20 A. That one was low. Yes, sir. And the respiratory
21 rate was slightly high. Yes.

22 Q. The hospitals that you work in--

23 A. Yes, sir.

24 Q. --do they have protocols about administering oxygen?

25 A. I'm sure they do. I'm not sure. I haven't looked

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1 at their policies and protocols recently. About when to
2 administer it? How to administer it?

3 Q. Well, for instance, Glenwood Hospital-- How often
4 do you work there?

5 A. I work several shifts a month there.

6 Q. You're not familiar with any policy that relates to
7 the level of oxygen in a patient's body?

8 A. A policy related to the oxygen in their body?

9 Q. Oxygen level in the blood. You don't know--

10 A. I don't--I don't think you're-- You mean of when to
11 give them the oxygen, of when we have to--

12 Q. Yeah.

13 A. --put a patient on it?

14 Q. Let's go with that.

15 A. I don't--I don't know of their--of when it--of a
16 certain level. Because every--every patient's going to be
17 deemed different of when they need the oxygen. It's
18 probably at the discretion of the provider. But I haven't
19 looked at their policies. No, sir.

20 Q. Are you aware in your review of the EMTALA laws
21 whether or not violation of hospital policy is prima facie
22 evidence?

23 A. I did not see anything about-- No, sir. I'm not.

24 Q. You hadn't looked at that. Did you consider that?

25 A. No, sir.

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1 Q. And is it fair to say you have no clue what the
2 policy was of Willis-Knighton South as far as administering
3 oxygen--

4 A. No, sir. I do not know their policy. Right.

5 Q. Okay. What other hospital did you say you worked
6 at?

7 A. Here in Ruston at Northern Louisiana Medical Center.

8 Q. Are you familiar with the protocol of that facility
9 as far as administering oxygen?

10 A. No, sir.

11 Q. How about in med school when you were going through,
12 do you recall any protocols that were suggested by the
13 instructors as far as administering oxygen?

14 A. No, sir.

15 Q. Would it be fair to say that in your opinions any
16 type of protocol or hospital policy has been excluded?

17 MR. ROBISON: Object to the form.

18 MR. BANKS: Yeah. That's a bad question. Let
19 me strike that and see if I can ask that a
20 little better.

21 Q. Okay. In rendering your opinions in this case, is
22 it fair to say and to tell the jury in this case that you
23 gave no concern as to the policy of Willis-Knighton
24 hospital as far as the protocol for administering oxygen?

25 A. That is fair to say.

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1 Q. Now, I want to show you what--

2 MR. BANKS: --I will mark as "White 1."

3 Q. Have you ever seen that document before?

4 A. No, sir. I haven't.

5 Q. Take your time and review it, and I want to ask you
6 some questions about it.

7 A. (Witness peruses document.)

8 MR. ROBISON: Sedric, do we know whose protocol
9 it is?

10 MR. BANKS: I thought that was the Willis-
11 Knighton one that y'all produced to us.

12 MR. HUTTON BANKS: It's Sobel 6, I think.

13 MR. BANKS: Sobel 6.

14 MR. HUTTON BANKS: Or 8.

15 A. Okay.

16 Q. Okay. Generally speaking, your opinion excludes any
17 information that's on the policy that you're holding there,
18 "White 1"?

19 A. My opinion doesn't exclude this, but I did not use
20 this protocol in coming up with my opinion, if that makes
21 sense.

22 Q. Yeah.

23 A. Yes, sir.

24 Q. Now, reading that protocol, do you think it has any
25 effect on your opinion?

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1 A. This protocol is for inpatients. In the ER, it's
2 different. And if they do have a protocol, I would think
3 it would be different than this protocol.

4 Q. Okay. Well, but you are an emergency room physician
5 and you're not familiar with any protocol in the places
6 where you work.

7 A. I have not read those protocols, if that's what
8 you're asking. So I don't feel comfortable answering
9 particular questions about them.

10 Q. Right.

11 A. I know we have protocols.

12 Q. Okay. I'll represent to you that the "White 1" that
13 you're holding there is the protocol for Willis-Knighton
14 South. And if I'm understanding correctly, what you're
15 telling me is that's the admission--that's for hospital
16 patients--

17 A. I would assume that this is for the hospital
18 patient. I wouldn't-- This says that you're to reassess
19 the patient daily on 7:00 to 3:00 shift. So that would not
20 be pertaining to the ER and that's the first number one in
21 the protocol. So that's why I'm assuming this is
22 inpatient--

23 Q. Right.

24 A. --protocol.

25 **MR. ROBISON:** I just want to object to the

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1 characterization of--I'm not sure where we got
2 it. I don't know that that's the protocol for
3 Willis-Knighton.

4 **MR. BANKS:** Okay.

5 **MR. ROBISON:** And I'm not saying it's not. I
6 just--

7 **MR. BANKS:** I understand.

8 Q. Do you think the-- Well, first of all, you said to
9 reassess every day?

10 A. This one is a reassess daily on a 7:00 to 3:00
11 shift. That's why I'm thinking this is an inpatient
12 protocol.

13 Q. Gotcha.

14 A. Yes, sir.

15 Q. Would it be important to reassess the oxygen level
16 in an emergency room patient?

17 A. Yes, sir.

18 Q. How often would you want to do that to an asthmatic
19 child that's suffering?

20 A. They're on a continual monitor, most of the time.
21 If they're--if they're urgent enough to need oxygen, almost
22 always are they going to be on a continual monitor.

23 Q. Now, is it important that before you do your initial
24 assessment, that the number that you start with on the
25 oxygen level is on room air?

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1 A. If it's possible to obtain it, but if someone is in
2 distress, you're not going to wait just to get that number
3 to have something to go by.

4 Q. Okay. I mean, the child's suffocating and you're
5 going to try to save her. Right?

6 A. Theoretically, if a child is suffocating, yes.
7 You're going to start treatments right then.

8 Q. Was this child suffocating?

9 A. Was this child suffocating? I did not get a picture
10 of suffocating from this chart, no, sir.

11 Q. Tell the jury, if you will, what, in your mind, is
12 suffocating.

13 A. You came up with the word suffocating. Not me.
14 Right? What is suffocating? Someone who is unable to get
15 any oxygen or air and they're near trouble with respiratory
16 failure. I think of-- We don't use the word suffocating a
17 lot in medical terms. So I'm kind of guessing off of a
18 layman's definition of suffocating.

19 Q. Right. From medical terms, where would that oxygen
20 level have to drop before you would commonly refer to this
21 child as suffocating?

22 A. Suffocating, in the seventies probably, and I'm
23 totally guessing because there's no medical term of
24 suffocating related to pulse ox.

25 Q. Right.

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1 A. But I would say probably in the seventies.

2 Q. Do you know what this child died of?

3 A. I did not read the autopsy report. I just read that
4 ER visit and then that hospitalization. Yes, sir.

5 Q. So you have no idea what caused the death of this
6 child?

7 A. I do have an idea because I read the ER chart and
8 the hospitalization.

9 Q. Okay. What do you think this child died of?

10 A. Of respiratory failure.

11 Q. Suffocation?

12 A. I would not use the word suffocation.

13 Q. What's the difference between respiratory--

14 A. I don't know--

15 Q. --failure and suffocation?

16 A. I don't have a medical answer for that.

17 Q. Okay.

18 A. Just because we don't use the word suffocation in--
19 in--

20 Q. Okay. It says in "White Number 1," that if these
21 SaO2 less than ninety-two percent on room air and/or PaO2
22 less than fifty on room air, you place the patient on
23 minimum level O2 and titrate to maintain saturation of
24 ninety-two percent or more.

25 A. Yes, sir.

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1 Q. What does that mean in layman's terms?

2 A. Well, she was at ninety-one. And so they're saying
3 if someone presents and their oxygen is around ninety-two,
4 you want to put them on oxygen enough to bring up their
5 oxygen level above ninety-two. So she was kind of
6 borderline according to those orders of needing oxygen.
7 And you put them on it until they come above--you put
8 minimal--just enough oxygen until you could bring their
9 saturation above that point. The fifty that you just read
10 is if you do a blood gas on them. When someone's severely
11 close to respiratory failure, you're doing a blood gas on
12 it because you want it even more--more accurate than a
13 pulse ox. You want to know more about it. You'll do an
14 arterial blood stick, and that's where that fifty comes
15 from. She did not have that done. So they're going by the
16 pulse ox.

17 Q. Okay. Reading on a little further here, I'm
18 skipping and I'm going to--

19 A. Sure.

20 Q. --give you the document back--

21 A. Yes, sir.

22 Q. --in case I'm missing something that you want to
23 talk about.

24 A. Yes, sir.

25 Q. But under the guidelines in the last little

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1 paragraph there, let me let you read that and I'll mark it
2 for you.

3 A. Yes, sir.

4 Q. Would you read that particular highlighted section
5 in "White Number 1"?

6 A. Yes, sir. "Patients on a ventilator will have O2
7 weaned per protocol to maintain an O2 saturation of ninety-
8 two percent or greater or a PaO2 of sixty or more.
9 Patients will have the O2 protocol continue upon extubation
10 and titrated to nasal cannula at minimum level."

11 Q. Is it fair to say that whether the patient is in the
12 emergency room or admitted to the hospital, that the goal
13 and the object is, from the physician's standpoint, is to
14 maintain an oxygen level?

15 A. Yes, sir. This protocol that you're highlighting is
16 a patient on a ventilator. She's not--

17 Q. Right.

18 A. --not on a breathing machine. She was already down
19 to this titrate--she's on a nasal cannula at minimal is
20 where she started. So, yes, you titrate them as needed,
21 but she didn't need this protocol wouldn't--wouldn't be to
22 her, this part, because she was never needed to be on a
23 ventilator.

24 Q. How would you know when a patient needs to be on a
25 ventilator?

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1 A. When their O2 sat remains low despite breathing
2 treatments despite supplemental oxygen starting with the
3 nasal cannula, then to a ventimask, then to a non-
4 rebreather, and they're continuing to have respiratory
5 distress that's worsening instead of improving. And then
6 you would do a blood gas if you truly thought they were
7 near respiratory failure to see what the oxygenation--the
8 PaO2 is in the blood.

9 Q. Have you ever heard the term washout?

10 A. Yes, sir.

11 Q. Tell me what that means to you.

12 A. For asthma patients?

13 Q. Please.

14 A. When you're breathing so fast or your breathing is
15 not effective enough that you're not able to exchange the
16 oxygen in your--in your lungs. It's not something I use
17 very often, to be honest, washout.

18 Q. Okay. Have you ever heard the term washout used
19 with respect to maintaining an oxygen level in a patient?

20 A. No, sir.

21 Q. Okay. Well, let me ask you this. If you have a
22 patient who has a breathing problem and you think the first
23 thing we're going to do, before we take any vital signs or
24 anything else, we're going to give some oxygen to this
25 patient who's struggling to breathe.

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1 A. Okay.

2 Q. Okay. Would you want to know how that oxygen
3 treatment faired? In other words, whether they improved or
4 whether they cannot maintain the oxygen that's given to
5 them?

6 A. Absolutely.

7 Q. How would you do that?

8 A. At the same time you're placing the patient on the
9 oxygen, you're doing the patient's vital signs and,
10 nowadays, the machines are at the bedside. So at the same
11 time when someone's getting the oxygen equipment, the pulse
12 ox has been placed on their finger. There's also pulse
13 oxes at triage when they're being brought in at the--at the
14 door.

15 Q. Yes, ma'am. And would it be fair to say that as
16 long as that oxygen is going into that four-year-old child,
17 those oxygen levels are going to be inflated?

18 A. If she's improving--if she's responding to it, yes.
19 And that's your goal. Yes, sir.

20 Q. Okay. And would the goal also be to maintain that
21 level of oxygen that's desired?

22 A. Absolutely.

23 Q. Okay. All right. Now, in this situation, let's
24 assume that the patient, this four-year-old, is getting
25 oxygen--

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1 A. Yes, sir.

2 Q. --and she comes in at ninety-one percent on room air
3 and the doctors decide that she needs some oxygen--

4 A. Yes, sir.

5 Q. --and they give her some oxygen.

6 A. Uh-huh (yes).

7 Q. And you're testing her the whole time.

8 A. Uh-huh (yes).

9 Q. Would you want, just out of curiosity, take the
10 oximeter off?

11 A. Absolutely.

12 Q. And then test her?

13 A. You keep it on while you take the oxygen off of her,
14 yes, sir.

15 Q. Okay. And how long would you wait before you figure
16 out whether she's maintaining a level or she's not
17 maintaining a--

18 A. There's not a magic number, but it takes maybe a few
19 minutes, but you like to know that it's going to stay there
20 somewhere between fifteen and thirty minutes. That was
21 actually done on this patient.

22 Q. Okay. Show me in the medical records where it was
23 done.

24 A. Okay. If you'll notice at-- The patient was taken
25 to radiology--let me see where I have that written down.

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1 After the first treatment, I think the patient was taken to
2 radiology between treatments and the--and it's noted in the
3 chart--I don't think I have it in front of me, but the
4 patient was taken off the oxygen and went to--and went to
5 radiology. If that patient--if the saturation would not
6 have remained elevated, they would've not taken the patient
7 to radiology off the oxygen. So that tells me that that
8 breathing treatment worked, it helped--started to improve
9 her, and that she was more stable enough that she could at
10 least go to x-ray and get an x-ray. An x-ray can take
11 anywhere from ten to fifteen, twenty, thirty minutes to
12 have done. So the fact that she was able to do that off of
13 oxygen tells me that she was improving.

14 Q. Okay. Would you want to then follow that up?

15 A. Absolutely. And that--the--if you look at her
16 reassessment of her vitals, her oxygen at that time is
17 ninety-nine percent. And that's at 3:23 which is forty-
18 five minutes before she got discharged, it was at ninety-
19 nine percent.

20 Q. And do you know whether or not the ninety-nine
21 percent--how long--let me stay with the ninety-nine percent
22 result. Do you know if she was still on oxygen at that
23 time?

24 A. Well, she was taken off of it to go to radiology at
25 2:46 and it does not say that she was placed back on it on

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1 the chart and nor does the ninety-nine percent say that it
2 was on oxygen. Usually, if a patient's on oxygen with a
3 pulse ox, they're going to say on two liters, on one liter,
4 on bi-pap, on ventimask.

5 Q. So you think that the ninety-nine percent was not on
6 room air or it was on room air?

7 A. I do think it was on room air. Yes, sir. I do.

8 Q. And the reason being again?

9 A. Because she was--went by stretcher off oxygen to
10 radiology. And if she was doing well enough to go then, I
11 do not see the need for her to put back on it. I will say
12 that when she came back, she had a breathing treatment done
13 at 3:16, and it does not say anywhere that she had to go
14 back on her oxygen after that.

15 Q. Okay. And was there another set of vital signs
16 taken?

17 A. Those were the only two that I saw.

18 Q. Okay. Well, let's go to the second set of vital
19 signs.

20 A. Yes, sir.

21 Q. Were those normal?

22 A. Those were the--the guidelines that I saw, her
23 respiratory rate thirty-four is within the normal. It's
24 the high normal. Her ninety-nine percent is definitely
25 normal. Her one forty-six could be within normal if you

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1 look at different sites, and I apologize for not having a
2 set normal with me. It's improving whether it's the upper
3 limits of normal or just above. I'm not sure. But the
4 most important thing to me was that it was coming down.

5 Q. Okay.

6 A. Yes, sir.

7 Q. And that was at three--

8 A. 3:23.

9 Q. 3:23.

10 A. Yes, sir.

11 Q. Okay. And twenty-two minutes later, she was
12 discharged home?

13 A. Her order was written there at 4:00, I believe, is
14 when she actually left the facility, or 3:59. The nurse
15 actually discharged her at that time.

16 Q. You see the 3:44 entry of Decadron steroid?

17 A. Yes, sir.

18 Q. What is a Decadron steroid?

19 A. A steroid is an anti-inflammatory which helps to
20 treat the inflammation in the alveoli in the lungs that's
21 causing the wheezing and the trouble breathing. Steroids
22 are used as the second step in an asthma exacerbation, if
23 needed. Sometimes, we give just Albuterol. Sometimes, we
24 give Albuterol with steroids. This patient was given a
25 shot of steroids prior to discharge as well as a

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1 prescription of some oral steroids.

2 Q. And would it be fair to say that the Decadron was
3 administered mainly for inflammation?

4 A. For inflammation? Yes, sir.

5 Q. How long does it take for that steroid to take
6 effect?

7 A. It can be six to eight hours. It's long-term. It's
8 not an acute treatment.

9 Q. Okay. Tell me why you would not want to wait six to
10 eight hours to find out if the inflammation is going to be
11 controlled by the steroid before you discharge the child.

12 A. Because he felt the child was stable enough to be
13 discharged home to do nebulizer treatments at home. It is
14 documented that the patient has a nebulizer machine at
15 home.

16 Q. That's the Albuterol?

17 A. Yes, sir. Yes, sir.

18 Q. I thought we talked earlier, maybe I missed it but
19 to make sure that we're on the same page here. I thought
20 we talked about Albuterol not treating inflammation, just
21 simply opening the airways.

22 A. It does. And that's how you treat--treat asthma.
23 That's considered a rescue medicine as well as some type--
24 Some people put them on a low-dose of a maintenance. Her
25 maintenance medicine is Dulera that she was doing twice a

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1 day which was a combination steroid inhaler and a long-
2 acting Albuterol.

3 Q. Tell us, if you will, how the inflammation effects
4 the breathing.

5 A. It only effects the breathing if the inflammation's
6 preventing--it's causing congestion and prevention of
7 oxygen exchange. So sometimes they may have a little bit
8 of wheezing. They may have no wheezing. They may have a
9 little bit of tachynpea or breathing a little fast. But
10 that is the primary treatment of asthma.

11 Q. So the Albuterol is going to open the airway. The
12 steroid Decadron is going to treat the inflammation--

13 A. Uh-huh (yes).

14 Q. --but we really haven't determined whether this
15 steroid is going to work or not to reduce that inflammation
16 until six or eight hours after it's administered. Is that
17 right?

18 A. The steroid kicks in six or eight hours later. Yes,
19 sir.

20 Q. What happens if the steroid doesn't work?

21 A. Well, they're given--they have Albuterol medicine at
22 home. Sometimes mild asthmatics are not even given
23 steroids. They're given an Albuterol treatment or two and
24 given their medication.

25 Q. Doctor, would you agree with me that the Albuterol

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1 treatments at home didn't work and that's why she was at
2 the hospital?

3 A. I will agree with you that her first treatment that
4 they attempted to give her did not work. Yes, sir.

5 Q. And the only inflammation treatment that she got was
6 at 3:44 in the morning, twenty-two minutes before
7 discharge?

8 A. Yes, sir. Well, and her Dulera, assuming she's
9 taking it as she's supposed to.

10 Q. I'm sorry?

11 A. Her Dulera which is her home medication.

12 Q. Okay.

13 A. Yes, sir. She's on that so she should have a small
14 dose on board if she's taking her Dulera.

15 Q. Did you notice there were some x-rays done at 3:39
16 in the morning?

17 A. Yes, sir.

18 Q. Before the steroids were administered?

19 A. Yes, sir.

20 Q. Did you notice anything unusual about those x-rays?

21 A. No, sir.

22 Q. Okay. Do you know what infiltrates are?

23 A. Yes, sir.

24 Q. Tell me what they are, please.

25 A. Well, this child had perihilar infiltrates which can

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1 be nothing, which can be acute, which can be inflammation
2 which can be fluid which can be infection. It's a very
3 non-specific.

4 Q. Is it indicative of pneumonia?

5 A. No, sir.

6 Q. Doctor, can you think about that a second and tell
7 me again.

8 A. Perihilar infiltrates are not indicative of
9 pneumonia. No, sir.

10 Q. All right. It's an inflammation?

11 A. Yes, sir.

12 Q. Okay. And that inflammation that was showing up in
13 the chest x-rays at 3:39 wasn't going to be treated until
14 we administered the steroids at 3:44. Correct?

15 A. Some of it. Yes, sir. And--

16 Q. And that inflammation was going to remain in place
17 and really it's kind of an unknown until six or eight hours
18 later. Correct?

19 A. It's not an unknown because she'd had that before
20 and that's a very common finding for asthmatics, and she'd
21 had it before and had done well.

22 Q. Let me ask you, Doctor, just out of curiosity. No
23 one has a crystal ball and I'm certainly not going to hold
24 you do that, but do you think if you would have been there,
25 this child would've died?

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1 A. Yes, sir. Unfortunately. Because I feel I would've
2 discharged her as well.

3 Q. I see. And you would've discharged her based on
4 what? The vital signs? Or--

5 A. The reassessment, the complete reassessment.

6 Q. Reassessment.

7 A. Yes, sir.

8 Q. Who did the reassessment?

9 A. The provider and the nurse.

10 Q. Okay. Which nurse?

11 A. I did-- You'll have to look in the chart to see.
12 But the provider is the one who decides if the patient is
13 going to be discharged or not.

14 Q. That's the doctor?

15 A. Yes, sir.

16 Q. Okay. And--

17 A. Or it can be a mid-level provider. In this case, it
18 was a doctor. Yes, sir.

19 Q. Have you ever discharged a patient without an exam?

20 A. Have I ever discharged a patient without an exam?
21 Yes, sir.

22 Q. You did that?

23 A. Yes, sir.

24 Q. Have you ever discharged a patient without knowing
25 what the vital signs were?

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1 A. Without knowing what the repeat vital signs were? I
2 haven't all-- Yes, sir. I've seen an initial set. Do I
3 always require a second set? No, sir.

4 Q. How do you know what the vital signs are if you
5 don't take the vital signs?

6 **MR. ROBISON:** Are we talking about on an
7 initial set or an in--

8 **MR. BANKS:** No. I'm sorry. That's a poor
9 question. Let me strike it and start over.

10 **WITNESS:** Okay.

11 Q. Do you agree with me, Doctor, that it's standard
12 medicine not to discharge a patient without taking the
13 vital signs?

14 A. That is not standard medicine.

15 Q. Not from the emergency room. You--you would--

16 A. You can't make a-- It depends on the diagnosis and
17 what the patient has. If you need a reset--a reset of--
18 another set of vital signs.

19 Q. Let's take this patient--

20 A. Yes, sir.

21 Q. --who was struggling to breathe--

22 A. Okay.

23 Q. --who has a history of asthma--

24 A. Yes, sir.

25 Q. --whose home treatments didn't work, who is at the

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1 hospital, who receives some Albuterol and receives a
2 steroid to combat the inflammation and then, twenty-two
3 minutes later, discharged without any vital signs. Is that
4 standard, Doctor?

5 A. Without any vital signs documented? I believe that
6 patient was still on a monitor as part of his--

7 Q. Oh, you do?

8 A. --reassessment. I do. Because there's no reason to
9 take him off of the monitor before you discharge them.

10 Q. Where is that in the notes?

11 A. I don't-- I said I believe that.

12 Q. But it's not in the record?

13 A. I do not see that. No, sir.

14 Q. You're making that up?

15 A. I'm not making it up. I told you I didn't see it.
16 My assessment of reading the chart was the-- The provider
17 wrote that he reassessed the patient. He didn't say if he
18 did have vitals or didn't have vitals. There's none
19 documented in there. I totally agree with that. Yes, sir.

20 Q. Is there a rule of medicine that if it's not
21 documented, it didn't happen?

22 A. No, sir. That's a rule of lawyers, not of medicine.
23 I don't mean to be crude, but it--

24 Q. That's fine.

25 A. --really isn't and we're--and we're awful. When an

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1 ER is busy that we don't always document like we're
2 supposed to.

3 Q. I see in your report--or I'm sorry--in the medical
4 records, I see a notation at 3:50 a.m. that the patient's
5 condition has returned to baseline. Do you see that? Do
6 you remember that?

7 A. The provider wrote that?

8 Q. Right.

9 A. Yes, sir.

10 Q. What does that mean?

11 A. To him, he feels like the child's back to their
12 usual self. If the child was playful, if the child was
13 active, if there was no further wheezing, then, to him, it
14 was the child's baseline.

15 Q. It doesn't mean anything about vital signs?

16 A. It could be.

17 Q. Okay. What would be the relationship?

18 A. You would have to ask-- I mean, that provider, what
19 his definition of that is, sir.

20 Q. Well, what is your definition? When you read that
21 in the record, what did you believe the baselines were as
22 so far as vital signs?

23 A. That he felt the child was back to their usual
24 status. If--if this child is known to these--to these
25 providers, as you said, and they've seen her--seen her

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1 before, and we've all seen an asthmatic and we've seen a
2 healthy child, and we've seen a child in respiratory
3 distress, if she's back to baseline, that tells me she's
4 interacting with mom, she's not having trouble breathing.
5 It could've been, you know, you'll have to ask him about
6 his baseline. That's what it--that's what it appeared to
7 me.

8 Q. Okay. In looking at the--

9 A. Because, sometimes, we-- Can I just add this?

10 Q. Oh, yeah. Sure.

11 A. Sometimes, we do discharge people that are not back
12 to baseline, but they're improving and they're stable
13 enough to go home. So that holds a lot to me that he said
14 back to baseline, that it's not just-- The child had been
15 discharged prior, if you read some of those other ones.
16 There still have some slight wheezing, but much improved,
17 or could've still had tachypnea. You don't always wait
18 till they're totally at baseline.

19 Q. Did you notice in some of those prior visits that
20 she was hospitalized with a ninety-five percent oximeter
21 reading?

22 A. I did not--I don't remember specifically. I'm not
23 surprised because that's just one of several things that
24 you look at.

25 Q. And what would be the others that you look at?

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1 A. Her respiratory distress, how she responded. If you
2 look at your protocol, at the bottom of it, it says a
3 pediatric child needs oxygen and I think it says pediatric
4 is to have an O2 maintained at ninety-five or greater. So
5 that's kind of borderline if they're at ninety-five. The
6 good thing is our child was at ninety-nine when she went
7 home.

8 Q. Yeah. And you are convinced that that ninety-nine
9 percent is after a washout period of time where the room
10 air is allowed to get back into the lungs?

11 A. Yes, sir. Because-- And what helps me even more so
12 is the fact that she went to radiology at least thirty,
13 forty-five minutes prior off the oxygen. So if she was
14 doing well then, there's nowhere in there that states that
15 she needed to be placed back on the oxygen or having any
16 trouble.

17 Q. Okay. Coming back to what we've talked about here
18 before, in those prior visits in the emergency room that
19 you reviewed, did you see any mention of a protocol in
20 there?

21 A. Did I mention a protocol? No, sir.

22 Q. Do you see any mention of protocol in those--

23 A. No, sir.

24 Q. --prior visits?

25 A. No, sir.

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1 Q. Okay. Did you see any mention that or concern that
2 the patient might have bacterial pneumonia that the x-rays
3 is lagging behind and not showing up?

4 A. No, sir. But the patient had been placed on an
5 antibiotic two days prior so if they did have a touch of
6 pneumonia, they were on a very--they were on a decent
7 antibiotic at that time.

8 Q. So, really, what you're thinking, and make sure I've
9 got this right, you would tell the jury that this patient
10 was just bound to die, there was really nothing they could
11 do for her?

12 MR. ROBISON: Object to the form.

13 A. I'm going to say that this patient was discharged
14 appropriately to home. It's a very unfortunate event what
15 happened.

16 Q. What did happen, Doc? What did happen?

17 A. That's a very-- I mean, that's a good question.
18 I'm-- The patient obviously woke up several hours later
19 wheezing, in respiratory distress. According to the chart,
20 the grandmother tried to give another breathing treatment.
21 When she did not get better, she called the ambulance. And
22 at some time between her call and the ambulance call, I
23 believe when they arrived, and this is according to the
24 record, because I did not see the EMR--the--the ambulance
25 record of reading of how the patient was on their arrival,

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1 it was just when she got to the ER.

2 Q. How was she when she got to the ER?

3 A. She was--she was coding at that time. She did not
4 have a heartbeat. They were breathing for her. She had to
5 be intubated. It took two times to intubate her and that
6 they had started ACLS protocol at that time.

7 Q. Okay. So what would you tell the jury happened
8 between the discharge and the fact that when she returned
9 to the hospital, a different hospital, brain dead? What
10 would you tell the jury happened?

11 **MR. ROBISON:** Just object to the form. I don't
12 know if she was brain dead at that point.

13 **WITNESS:** Yeah.

14 Q. She wasn't brain dead?

15 A. I don't--I don't know if she was brain dead at that
16 time. She was coding at that time. Do people come back
17 from coding? That doesn't--that doesn't equate with brain
18 dead right then.

19 Q. Okay. So what would you tell the jury happened to
20 this four-year-old after she left the emergency room until
21 she returned to a different hospital coding?

22 A. That sometime in the next few hours she had
23 respiratory distress and the medicine either did not work
24 appropriately, for whatever reason, was not given
25 appropriately, did not work appropriately and by the time

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1 the paramedics arrived, she was in respiratory failure.

2 Q. Who would have given her the medicine that you just
3 mentioned?

4 A. Her mother or her grandmother. I believe the
5 grandmother was there.

6 Q. You think the grandmother did it? She didn't
7 administer the medicine properly?

8 A. I don't know. That's the grandmother's who's
9 documented in there.

10 Q. That right.

11 A. When people are in respiratory distress, sometimes
12 it's hard to give the Albuterol treatments. She tried and
13 then-- She tried initially, I think, according to the
14 report, and then called the ambulance.

15 Q. Have you ever seen that, Doctor, where Albuterol
16 just didn't work?

17 A. I've seen where it's-- Yes. And there's--whether
18 it was either appropriately or if someone is in distress,
19 was the machine-- You have-- You have to be compliant
20 enough to stay still to have the oxygen mask on you to get
21 the medicine in there--to get the medicine into the lungs.
22 That's why the nebulizer machine-- I've seen people come
23 in and say that theirs isn't working at home or it didn't
24 do well and we give them a treatment with a respiratory
25 therapist. Sometimes we have to-- It does work.

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1 Q. So you would tell the jury that you think grandma
2 didn't do it well?

3 A. No. I would not tell the jury that.

4 Q. Okay. So then what else? If grandma didn't do,
5 what happened?

6 A. I am not-- I'm going to be the first to tell you
7 that I am God and I don't know what happened but
8 unfortunately the child died several hours later.

9 Q. Okay. Now, explain to the jury the mechanics.
10 What's going on in the body between the time that the
11 hospital discharged her from the emergency room and the
12 time when she is brought back coded to a different
13 hospital. What's happening mechanically in the body?

14 A. I can explain to them about asthma and asthma
15 attacks and respiratory failure and I can explain to them
16 the medication that was given to the patient. And I can
17 explain the child's body can compensate up to a certain
18 point and then the child coded.

19 Q. How would you know if the child's body is coping?

20 A. Well, unfortunately, the child, according to the
21 record, was sleeping and then woke up this way, according
22 to grandma. I wouldn't blame any of the family at all on
23 this horrible thing.

24 Q. No. And maybe my question is poor but let's see if
25 I can get you focused on what I want to talk about.

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1 A. Yeah. Okay. Yes, sir.

2 Q. I'm talking about between the discharge from Willis-
3 Knighton South and the time when the patient, the four-
4 year-old patient, is transported by ambulance to Willis-
5 Knighton Bossier. What happened to the child's body? What
6 was going on inside?

7 A. I would really-- Before I answer that, would like
8 to read the death certificate to see what the coroner
9 actually said it was. I mean--

10 MR. HUTTON BANKS: Autopsy or death
11 certificate?

12 WITNESS: The autopsy report.

13 A. I mean, to just give you off the cuff, if I can help
14 explain it to the jury. I don't think-- I don't feel like
15 the patient was inappropriately discharged. I think it's
16 an awful, awful sad case. I think-- Asthma-- I've seen
17 several people die from it. It's a very unfortunate-- It
18 is a-- It's very sad but it--

19 Q. Is it painful, Doctor?

20 A. It's not-- Is it painful to have trouble breathing?
21 I think it's uncomfortable. Have I had asthma? I do not
22 have asthma.

23 Q. Would you tell the jury that this child did not
24 suffer in between the discharge--

25 A. I would not tell the jury that.

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1 Q. Did she suffer physically?

2 A. The child-- We suffer. Anytime she had a asthma
3 attack, she was suffering from having some difficulty
4 breathing. Is it painful? I don't think so. You'd have
5 to ask the asthma asthmatic that's had a couple of really
6 bad flare-ups and had to be intubated from it. She had
7 never had a severe enough one that had to be intubated,
8 ever, since the charts from six months on. She had never
9 had one that bad.

10 Q. Do you think the child knew that she was in trouble?
11 A four-year-old, can they perceive the fact--

12 A. I think breathing is a basic thing. I think she
13 can-- If she can tell them or can't tell them, you can
14 hear wheezing, you can see distress.

15 Q. Is there any medical condition that you're aware of
16 that you can't hear the wheezing going on but the physician
17 can determine there's something really seriously wrong
18 here?

19 A. In an asthmatic?

20 Q. Right.

21 A. Yes. You can have the asthma so severe that they're
22 not hardly having airway movement at all and not hear
23 wheezing. And then when you give a breathing treatment, as
24 it's opening up the airway, the wheezing can get worse
25 initially and then better. But that person is going to be

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1 very--in much distress. Even if you're not hearing it,
2 they're not sitting here like you and I. They're going to
3 be very uncomfortable.

4 Q. Did you notice that the family, as noted in the
5 records, observed respiratory failure.

6 A. I don't understand what you're saying. They
7 observed it when?

8 Q. When they called the ambulance?

9 A. I did not see the run sheet of the call. I'm
10 reading the ER chart and I don't--I don't know what they
11 said when they called. Do you have the run sheet of when
12 the patient was picked up by the ambulance?

13 Q. I don't know if we have that, Doctor. I'm not sure.

14 A. Okay. Well, I will say that on the ER note that the
15 doctor wrote that CPR was not being done by the bystander,
16 so I'm assuming that the patient did not code in front of
17 the parents or they didn't recognize it and that the
18 ambulance guys recognized or it occurred in front of the
19 ambulance guys.

20 Q. Okay. You think also, Doctor, coming back to what
21 we talked about early-- Well, before we leave that. Do
22 you think a four-year-old can explain to a doctor that "I'm
23 feeling better, Doctor. I'm okay."

24 A. They can say, they can show it, they can act it. I
25 think you can say, "Do you feel better?" and they can smile

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1 or say yes or run around the room, which shows you they're
2 feeling better. Drinking their juice. They're feeling
3 better. Yes, I do.

4 Q. Okay. Did you see where this patient was running
5 around the room?

6 A. I didn't see it documented. No, sir.

7 Q. Did you see where she was drinking juice?

8 A. No sir.

9 Q. Did you see any of those things that you're talking
10 about that indicated to you that the patient's fine?

11 A. No. But I saw the note of the reassessment that the
12 nurse said that the patient was feeling better. So you'd
13 have to ask the nurse what she was observing that made her
14 say that. But that's how I reassess.

15 Q. I understand.

16 A. Yes, sir.

17 Q. I want to cover just a couple of quick questions and
18 answers, if you will, Doctor, just to kind of cover some
19 ground here. Tell me whether you agree or don't agree,
20 please?

21 A. Yes, sir.

22 Q. Vital sign assessment is essential in determining a
23 patient's health status?

24 A. Where are you reading this from? Is this from a
25 medical book?

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1 Q. I'm just asking you if you believe that.

2 A. Do I believe that vital signs are essential?

3 Q. In determining a patient's health status.

4 A. They are a part of it. It's not absolute but I do
5 think it's important.

6 Q. Okay. If you'll just tell me whether you agree or
7 don't agree.

8 A. Okay.

9 Q. Vital sign assessment is essential in the
10 determination of a patient's health status.

11 MR. ROBISON: Are we talking about in an ER
12 setting or sitting here?

13 Q. Sure. ER setting.

14 A. So does essential-- Can you give me your definition
15 of essential? Is it definitive; is it absolute? It's
16 important. That's why--

17 Q. Okay. You'd tell the jury it's not essential; it's
18 something else?

19 A. It's important.

20 Q. Important?

21 A. Yeah.

22 Q. Okay. The second thing that I want to talk to you
23 about. An alteration in a patient's vital signs can
24 provide objective evidence of the body's response to
25 physical and physiological stress or changes in

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1 physiological function.

2 A. Yes.

3 Q. Okay. Vital sign monitoring is a core function of
4 the registered nurse. Agree or not agree, Doctor?

5 A. Say it again.

6 Q. Vital sign monitoring is a core function of the
7 registered nurse.

8 A. Yes.

9 Q. Monitoring of vital signs is an essential component
10 of caring for all patients in order to assess treatment,
11 effects, detect procedural complications, and identify
12 early signs of clinical deterioration.

13 A. No.

14 Q. You wouldn't agree with that?

15 A. No, sir. Because it says all. So I don't think
16 it's necessary in all cases.

17 Q. And how about in this case? Would it be true in
18 this case?

19 A. Read it again it again, please sir.

20 Q. Sure. Fair enough. Monitoring of vital signs in
21 this case is an essential component in order to assess the
22 treatment effects and detect procedural complications and
23 identify early signs of clinical deterioration.

24 A. Yes.

25 Q. When this child arrived at the emergency room at two

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1 in the morning, I think it was, on February 10th, was she
2 stabilized then?

3 A. She came in. Was she stable when she arrived?

4 Q. Yeah.

5 A. She was not. No, sir.

6 Q. Would you agree, Doctor, that unstable patients may
7 need continual observation and frequent monitoring of vital
8 signs until they are stabilized?

9 A. Yes.

10 Q. And if I'm understanding correctly, you would tell
11 the jury, in this case, that you don't really need vital
12 signs at discharge to know whether the patient was stable
13 or not stable?

14 A. I would tell them that there were no vital signs
15 documented on this patient at discharge.

16 Q. Fair enough. Would agree or not agree that the key
17 risk addressed by emergency department policies is to
18 prevent a serious adverse event by detecting physiological
19 disturbances and initiating treatments in a timely and
20 effective manner?

21 A. That's pretty wordy. Can you repeat yourself? I'm
22 sorry.

23 Q. Sure. No problem. Anytime you want me to repeat
24 something, no problem at all, Doctor.

25 A. Okay. Thank you.

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1 Q. The key risk addressed by emergency department
2 policies is to prevent a serious adverse event by detecting
3 physiological disturbances and initiating treatment in a
4 timely and effective manner.

5 A. I really don't like all that wording, but I think
6 I'd say yes.

7 Q. Okay. The next statement, Doctor. The four main
8 aims of effective patient observation are, Number One,
9 monitoring of physiological variables to evaluate treatment
10 effects. Would you agree with that as being one?

11 A. Yes, sir.

12 Q. Would you agree that Number Two would be to maintain
13 a thorough assessment with a 24-hour a day hospital
14 emergency room department?

15 A. To maintain a thorough assessment-- That's the key
16 to observation.

17 Q. Right.

18 A. You're talking about observation within the ER
19 setting?

20 Q. Right.

21 A. Okay. Because different people have different
22 observing within that ER stay versus an observation bed
23 versus doing a six or eight hour observation. So we
24 observe most of our patients at sometime during their ER
25 visit.

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1 Q. Okay. Number Three that another aim of effective
2 patient observation is for the early detection and
3 treatment of post-procedural complications.

4 A. Okay.

5 Q. Do you agree with that?

6 A. Yes.

7 Q. Okay. The fourth main aim of effective patient
8 observation is the early detection and treatment of a
9 deteriorating via an emergency response.

10 A. Sure.

11 Q. Okay. Would you agree that vital sign assessment
12 frequency ensures that emergency department patients will
13 not be discharged in an unstable condition?

14 A. Does it ensure? Can I ask you a question?

15 Q. Yeah. Sure.

16 A. Is this from your expert witness that you're asking
17 me if I agree with his statements?

18 Q. No, ma'am. I'm just--

19 A. Or is this from a book or is this from-- Where is
20 this--

21 Q. Well, now that you mention it, Doctor. Let me ask
22 you this. If we wanted to pull the "bible" so to speak,
23 the absolute medical authority that Dr. White believes in,
24 you with me?

25 A. Uh-huh (yes).

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1 Q. If we wanted to open it up in front of the jury and
2 read from it and we wanted to tell the jury that this
3 source, this medical source that Dr. White, as the bible,
4 it would tell us how not to discharge an unstable patient.
5 What text would you go to?

6 A. I wouldn't be able to give you a name of that. I
7 use very-- We all use different texts as well as our
8 clinical judgment on saying this.

9 Q. Okay. Which text or medical authority would you
10 rely on to tell you when to not discharge an unstable
11 patient?

12 A. I don't have one over the other that I would give
13 you.

14 Q. Well, let's do it this way. Give me two or three of
15 them that you really consider authorities insofar as
16 discharging an unstable patient.

17 MR. ROBISON: Wait, what do you mean by
18 discharging an unstable patient.

19 A. You mean appropriate treatment of the emergency
20 medical care?

21 Q. No. I'm talking about. This is how we go about--

22 A. Appropriate discharging?

23 Q. This is how we go about making sure that we do not
24 discharge a patient in an unstable condition. This is it.
25 This is the page we ought to read. What authority do you

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1 rely on?

2 A. You don't-- The books on emergency medicine or the
3 complete care of a patient, and they may be included in
4 that.

5 Q. Okay. What books are we talking about?

6 A. Tintinalli's of Emergency Medicine is very good and
7 probably the--one of the leading authorities. For
8 pediatrics maybe Harriet Lane on emergency treatments of
9 that. UpToDate is a culmination of different treatments on
10 that. Rosen's has a good book on that. I mean, there's
11 several of them. I don't use just one as that on whether
12 or not to discharge or admit a patient.

13 Q. Right.

14 A. Because I think that's the question here, right, of
15 whether the patient should have been discharged or not. Is
16 that the EMTALA violation that we're discussing?

17 Q. Is that what you thought it was?

18 A. Is that what you're-- I had a hard time reaching on
19 EMTALA violation on this.

20 Q. I think you told us that. And your evaluation of
21 EMTALA violations, if I'm understanding correctly, did not
22 consider any hospital policy, it didn't consider any
23 interpretation of EMTALA guidelines. Correct?

24 A. Did I look at-- I did look at the EMTALA guidelines
25 when looking at this. Yes, sir.

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1 Q. Any of the apply that you thought would particular--

2 A. I did not think they applied. No, sir, I did not.

3 Q. Would you agree that vital signs assessment serves
4 as an early warning of a change in a patient's condition?

5 A. It can. Yes, sir.

6 Q. Have you ever read anything about what can happen
7 when your vital signs aren't stable at discharge time?

8 A. Have I ever read anything about that? Not in
9 particular.

10 Q. Would any of those medical texts that you've
11 mentioned here this afternoon, would any of those address
12 what can happen when your vital signs aren't stable at
13 discharge time?

14 MR. ROBISON: Are we talking about in this case
15 or--

16 Q. No. Just in the medical text.

17 A. That's a very simplistic that doesn't say that in
18 the book about patients stabilizing. If I can add, do we
19 always wait until vital signs are stable before we
20 discharge patients? No. If we did our hospitals would be
21 more overcrowded than they are.

22 Q. Do you know of any dangers of releasing a patient
23 with an unstable vital sign?

24 A. What is your definition of unstable?

25 Q. Not normal.

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1 A. Okay. Abnormal doesn't have to mean unstable. So
2 you can have an abnormal vital sign, which is out of the
3 norm of what is-- It's like a bell curve. It can be out
4 of the abnormal, but not necessarily mean the patient is
5 unstable.

6 Q. What would you tell the jury an unstable vital sign
7 is?

8 A. I would say that abnormal and unstable are
9 different, and do I think she had any unstable? No. Do I
10 think it could've been abnormal on certain perimeters? It
11 could be-- Which if you look at different books, such as
12 if you want to look at Harriet Lane or a different
13 pediatric book, they can have different norms for a four-
14 year-old.

15 Q. Okay. Did you ask for any documents in this case
16 that you didn't get?

17 A. I asked for all the old ER records and the run
18 sheet, and I didn't get the run sheet. I think--

19 **WITNESS TO MR. ROBISON:** Did I ask for that? I
20 didn't ask for it?

21 **MR. ROBISON:** You asked for it.

22 A. I did ask for it. I asked for the run sheet when
23 they did go pick up the patient, and I didn't get that.
24 And the old ER records. Those were the two I asked for.
25 Yes, sir.

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1 Q. That you didn't get?

2 A. The one I didn't get was the run sheet.

3 Q. And what was the importance--

4 A. The ambulance. To know what was going on at the
5 house, to know what symptoms--what she presented as when
6 they got there, to know what they did or attempted to do
7 enroute. It sometimes will help with the-- When a--when a
8 patient comes in in arrest, the chart is not always
9 complete because they're worried about trying to save the
10 child's life. So, sometimes, the run sheet can give you a
11 better history or story. So I just wanted that for
12 completeness.

13 Q. Okay. Why did you not think that the 02 protocol
14 was not sufficiently important to review with respect to
15 your opinion of whether the hospital violated EMTALA in
16 this case?

17 A. Because when the patient was discharged, the patient
18 was stable with ninety-nine percent saturation. So there
19 was not a question in my mind that they followed the
20 protocol or not. They treated the patient who had an
21 emergency medical condition and the patient was stabilized.
22 So I didn't think to ask for the 02 policy.

23 Q. Okay. Have you ever been sued in a civil lawsuit
24 alleging medical malpractice?

25 A. Yes, sir.

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1 Q. How many times, Doctor?

2 A. I believe that's six times.

3 Q. And how did those cases come out?

4 A. They were all dropped.

5 Q. And have you ever been subject to a medical
6 negligence complaint?

7 A. Those were the-- Am I saying it right? Those were
8 the complaint-- I've had six complaints.

9 Q. So--

10 A. I had-- Well, those were six. I had one in
11 addition to that that was a letter to the board as a
12 complaint. It was never a suit. And I had to write a
13 letter explaining it, and then that was dropped. So that
14 would be the only thing besides that.

15 Q. And so just so we're clear.

16 A. Yes, sir.

17 Q. I'm saying complaints or lawsuits. Are you
18 considering a complaint a lawsuit?

19 A. Yes, sir.

20 Q. Have you ever actually had a lawsuit filed, where
21 the sheriff comes out and serves a petition and you got to
22 go to court?

23 A. Yes, sir. I think two of them may have been to
24 that-- Three were in Arkansas where I first started
25 practicing and I believe three were here. One--official

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1 the lawsuit was there and then one here where I was served
2 papers.

3 Q. In those lawsuits, who were the plaintiff?

4 A. The one in Arkansas was a twenty-two or twenty-four-
5 year-old female that had pneumonia.

6 Q. And what county?

7 A. Faulkner County.

8 Q. Faulkner.

9 A. Conway, Arkansas. Yes, sir.

10 Q. And it was an actual lawsuit?

11 A. Yes, sir.

12 Q. And then, here, in Louisiana, what parish was the
13 suit served?

14 A. Here in Lincoln.

15 Q. Lincoln?

16 A. Yes, sir.

17 Q. Do you consider yourself an expert in EMTALA?

18 A. No, sir.

19 Q. Have you ever testified as an expert in an EMTALA
20 case, if I haven't already asked you that? I apologize.

21 A. No, sir. You asked, but I haven't. No, sir.

22 Q. Okay. Would you be surprised if this child's death
23 was caused by pneumonia and hypoxic brain injury?

24 A. Would I be surprised? I do believe the patient did
25 have hypoxic brain injury that was on the--that

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1 hospitalization. I don't remember if it said pneumonia as
2 one of the diagnoses.

3 Q. Would it surprise you that this child had pneumonia?

4 A. Would it surprise me?

5 Q. If it turns out that she did?

6 A. It would be unlikely. It wouldn't surprise me. No,
7 sir.

8 Q. But it would be unlikely?

9 A. I would think so. Yes, sir.

10 Q. And why would you tell the jury that pneumonia would
11 be unlikely in this case?

12 A. Because she was on an antibiotic at the time. It
13 was started two days prior and she had a chest x-ray done
14 that did not show an obvious pneumonia. It had perihilar
15 infiltrates which is common with asthma.

16 Q. I'm going to leave this alone, but I just want to
17 make sure I understand.

18 A. Yes, sir.

19 Q. You're saying her death was inevitable?

20 A. I'm saying her death was unfortunate.

21 Q. And inevitable?

22 **MR. ROBISON:** Object to form.

23 A. I really don't want to say it was inevitable. It
24 was unfortunate. I don't want to use the word inevitable.

25 Q. Hypothetically, Doc, if this child would have been

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1 hospitalized and hooked up to the monitors, vital signs
2 that we've talked about, would there be a greater than
3 average chance that this child could've been saved?

4 A. Could they have been? Yes. A lot of people would
5 be saved if they were in the hospital than not. The
6 question goes back to were they inappropriately discharged.

7 Q. Right.

8 A. And I don't think they were--it was inappropriate.
9 If the child was in the hospital, would they have found
10 that--that's kind of putting that on the parents and I
11 really don't want to say that, for the parents' sake, to
12 tell them if you'd got the patient back sooner or if you
13 would've stayed with us, that's a hard prediction to make.

14 Q. If they would have stayed with you? What does that
15 mean?

16 A. Been admitted to the hospital. Stayed--stayed at
17 the hospital. Believe it or not, sometimes-- I'm going to
18 add this. Admissions are easier than discharges. And so I
19 don't you would risk doing that.

20 Q. Have you read Dr. Richard Sobel's report in this
21 case?

22 A. No, sir. I have not.

23 Q. Have you read his deposition?

24 A. No, sir. I have not.

25 Q. Is there any reason why you would not want to read

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1 those documents?

2 A. I don't think I needed his deposition to form my
3 opinion and I didn't want to be biased on it. I felt like
4 I had enough evidence right here.

5 Q. Okay.

6 A. Is he a-- Would you like me to read-- Is he an
7 asthmatic specialist?

8 Q. No. No.

9 A. A pediatric specialist?

10 Q. He's an EMTALA expert.

11 A. Okay. How do you become an expert in EMTALA?

12 Q. I think the court probably has the final say on
13 that.

14 A. Oh.

15 Q. The effects of Albuterol last four to six hours. Is
16 that correct?

17 A. The long-term, yes, sir.

18 Q. So--

19 A. They can. Yes, sir.

20 Q. How long does it normally take to know whether
21 Albuterol is working or not working?

22 A. Usually within fifteen minutes, ten to fifteen
23 minutes. You can--you can see some improvement pretty
24 rapidly.

25 Q. The home treatments of Albuterol that she received,

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1 this child received at home--

2 A. Yes, sir.

3 Q. --were those any different than the Albuterol that
4 was administered in the hospital?

5 A. As far as I know, no, sir. I believe it was just
6 straight Albuterol that she had at home. The Dulera was
7 different. But she had Albuterol at home, according to the
8 record, yes, sir.

9 Q. And this is my--

10 A. Uh-huh (yes).

11 Q. --my crass way of putting it.

12 A. Yes, sir.

13 Q. But there's no industrial strength Albuterol. I
14 mean, Albuterol is Albuterol.

15 A. They are different-- There are different strengths.
16 Yes. There are. There are different strengths.

17 Q. Is the hospital grade different than the home use
18 grade?

19 A. It just depends on what her prescription was as far
20 as to know if she had the same medication as we had at
21 home.

22 Q. Can you over-medicate with Albuterol?

23 A. Sure.

24 Q. And if you do over-medicate, how would you know
25 that?

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1 A. Well, you just look and see if she has some of the
2 side effects of Albuterol.

3 Q. Which are?

4 A. Breathing fast, fast heartrate, anxiousness,
5 nervousness, nausea, upset stomach. Those are the more
6 common ones.

7 Q. Would you agree with this, Doctor, that needing to
8 use Albuterol more frequently than usual may be a sign that
9 your asthma is destabilizing and you need to seek immediate
10 medical advice?

11 A. Yes.

12 Q. Your statement on page 1 of your report, Doctor, you
13 mention that approximately two hours after entering the
14 emergency department, "The patient was stable for
15 discharge." Was that based on a medical examination, that
16 statement?

17 A. My statement was based on review of the chart.

18 Q. Okay. Well, when you reviewed the chart, can you
19 show the jury the medical exam that would support that
20 statement?

21 A. No. That's the statement that the provider wrote.

22 Q. Oh, okay. I may have attributed that to you. I'm
23 sorry.

24 A. No. It says the doctor noted on the reassessment
25 that patient's condition had-- I'm sorry.

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1 Q. Okay. I think I--

2 A. Yeah. That's why I had it--

3 Q. --confused that and--

4 A. --in parentheses.

5 Q. --I apologize to you.

6 A. No. That's okay.

7 Q. But we want to take his statement that--

8 A. Yes, sir.

9 Q. --the doctor wrote here in the notes,--

10 A. Yes, sir.

11 Q. --and we want to show the jury on a big board the
12 medical exam that supports that. Where is that? The
13 medical exam?

14 A. It's not in the chart.

15 Q. Okay. Would you agree that once the medical
16 emergency is over with, the physician determines that we no
17 longer have an emergency medical condition, that you would
18 stop the treatment?

19 A. No, sir.

20 Q. Okay. Would you agree that compared to an adult,
21 the small size of a child's airway, it makes the child more
22 susceptible to obstruction by the tongue?

23 A. It can. Yes.

24 Q. Would you agree that room air contains twenty-one
25 percent oxygen?

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1 A. Yes, sir.

2 Q. Would you agree that children are belly breathers
3 because they rely heavily on their diaphragms?

4 A. Younger children can be. Yes, sir.

5 Q. And four-year-old, that qualifies as a younger child
6 in your mind?

7 A. I don't--they're not--I don't know what age they
8 stop using their diaphragm as much, but they're not
9 necessarily at four, belly breathers.

10 Q. Would you agree that when a child experiences low
11 cardiac output state, the child relies mostly on an
12 increase in heartrate?

13 A. Relies on that for what?

14 Q. To live. For--

15 A. Not just an increase in heartrate.

16 Q. To survive. I'm sorry?

17 A. That's kind of too generic to say it relies on the--

18 Q. You would not agree with that?

19 A. I would say that's too vague and it's not exactly an
20 appropriate medical statement. Can I just add this--

21 Q. Yeah. Sure.

22 A. I'm not-- Are you-- Is that from his expert
23 witness about the low cardiac output?

24 Q. No. I was just--

25 A. Or is that just a medical term? I'm not sure--

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1 Q. It was just a question that I had.

2 A. Low cardiac output, I'm not sure if that's relating
3 to the asthma. That's kind of a--that's why I don't feel
4 comfortable saying that. That's--

5 Q. Would asthma cause a low cardiac--

6 A. That's more of a cardiac-- Not necessarily. That's
7 why I'm not real sure about that.

8 Q. Okay. Fair enough. I'll have to get the exact term
9 you used, we were talking about not intervals of taking
10 vital signs, but I think your term was trends.

11 A. A trend. Yes, sir.

12 Q. You're saying that there's no trends here because
13 the child was monitored the entire time?

14 A. I did not say there was no trends. I said there was
15 a-- You can look at these two and look at a trend, that
16 the child seems to be improving as opposed to worsening.

17 Q. And you would think that the second set of vital
18 signs are normal?

19 A. I didn't say they were normal. I said they were
20 improved.

21 Q. Did we ever have--

22 A. From the first set.

23 Q. I'm sorry. I didn't mean to--

24 A. Go ahead.

25 Q. In your entire review of the chart, Doc, did you

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1 ever see a set of vital signs that you thought were
2 perfectly normal?

3 A. No, sir.

4 Q. Collectively, would that trend--or those sets of
5 vital signs that you have available--would they be
6 important, if not critical, as to whether the child is
7 stable or not stable?

8 A. They can be important. Yes, sir.

9 Q. Were they important in this case?

10 A. This set? Yes, sir.

11 Q. A stable heartrate over what period of time
12 determines whether a child is stable or not as far as his
13 heartrate?

14 A. The heartrate by itself doesn't determine if the
15 child's stable or unstable. You can have an abnormal
16 heartrate and still be stable as the child. This child's
17 heartrate is going--it has to be part of the picture
18 because it's had several doses of Albuterol. So is the
19 heartrate a little bit elevated from the Albuterol or
20 because the child is angry because you're holding a mask in
21 front of them, or is it because they're having trouble
22 breathing? So that's why the assessment is important.

23 Q. You just don't know. Do you, Doctor?

24 A. You just don't know from a--from a heartrate.
25 Right.

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1 Q. And the same question, it will be the same situation
2 involving blood pressure and pulse rate and oxygen
3 readings?

4 A. Not necessarily oxygen readings.

5 Q. What's different about the oxygen readings?

6 A. That's on a--on a finger, unless it's not--unless
7 it's not on there accurately, or they've had a blood
8 pressure cuff that's stopping the flow, that should be--
9 that should be accurate.

10 Q. Let me ask you. Without knowing the vital signs at
11 the time of discharge, how could you know with reasonable
12 medical certainty that the child's condition would not
13 deteriorate?

14 A. That the child would not deteriorate? I can tell
15 you with reasonable medical certainty that the child was
16 stable for discharge and that it's unlikely is what the--I
17 believe is what the definition. Is that what you're
18 asking, the definition of EMTALA is what they're--

19 Q. No. Let me go back and ask my question again.

20 A. Okay. Yes, sir.

21 Q. And let you--

22 A. Yes, sir. Yes, sir. Okay.

23 Q. Without knowing the vital signs at discharge, how
24 could any doctor know with reasonable medical certainty
25 that this child's condition would not deteriorate?

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1 A. Even with the set of vital signs, how do I know with
2 reasonable certainty? I do not think the vital signs will
3 give me reason--a difference in that, if that's what you're
4 asking.

5 Q. No. I'm not sure we're communicating.

6 A. Yeah. I don't necessarily understand. I'm sorry.

7 Q. No. No. No. No problem. And maybe I'm just not
8 asking the question in the right way. But we agree that
9 there were no vital signs taken at discharge. Right?

10 A. There were no vital signs documented. Yes, sir.

11 Q. Now, my question is without vital signs at the time
12 of discharge--

13 A. Without vital signs documented--

14 Q. --at the time of discharge--

15 A. --at the time of discharge. Yes, sir.

16 Q. --how would any doctor know with reasonable medical
17 certainty that this child's condition will not deteriorate?

18 A. Because he did a reassessment on the child.

19 Q. Without vital signs?

20 A. Without them documented. You'd have to ask him. If
21 the child was still on a monitor, he can look at the
22 monitor. Unfortunately, the nurse has to put the vital
23 signs into this electronic medical record. The machine
24 doesn't automatically do it. So just the fact that they're
25 not in here tells us they're not documented. But when he

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1 did his reassessment, was the patient on a monitor? I
2 cannot say.

3 Q. And the term washout that we talked about before--

4 A. Yes.

5 Q. --that's just totally unfamiliar to you?

6 A. It's not totally unfamiliar. We just don't use that
7 as a medical term a lot, as washout.

8 Q. What do you take it to mean? What do you believe it
9 means, washout, in this kind of text that we're dealing
10 with here?

11 A. Well, I don't even really like to give you a
12 medical-- I don't believe washout-- You're wanting to--
13 From your definition of washout was that the patient was
14 off the oxygen long enough, that the patient did well. I
15 don't think this-- The patient was off the oxygen long
16 enough to show that she was maintaining her O2 saturation.
17 I don't know really-- I mean, I know you-- I don't know
18 why you want to go back to the word washout.

19 **MR. BANKS:** Can we take a short break?

20 **WITNESS:** Sure. Yes, sir.

21 (OFF RECORD.)

22 Q. Doctor, I'd like to give you a copy of what I think
23 is your report--

24 A. Yes, sir.

25 Q. --and let you look at that.

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1 **MR. BANKS:** I've labeled it "White 2."

2 (Witness peruses document.)

3 A. Okay.

4 Q. That is your report?

5 A. Yes, sir.

6 Q. Okay.

7 **MR. BANKS:** I'd like to attach that to the
8 deposition along with "White 1."

9 Q. And I want to give you a document that is now--

10 **MR. BANKS:** --labeled "White 3."

11 A. Yes, sir.

12 Q. And it's another protocol and I just want to let you
13 review that for a minute, take your time and go ahead--
14 You might want to show it to counsel first. I'm sorry.

15 A. I'm sorry.

16 Q. And I'll represent to you, Doctor, in all fairness
17 to counsel and yourself, that document was produced in
18 another lawsuit, not this lawsuit. It was produced in
19 another lawsuit involving Willis-Knighton. And I just
20 wanted to ask you some questions about that--

21 A. Yes, sir.

22 Q. --after you've had time to look at it.

23 (Witness peruses document)

24 A. Okay.

25 Q. Okay. Do you see anything on there, Doctor, that

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1 you just disagree with?

2 A. I don't disagree with it, but, once again, I think
3 this is inpatient.

4 Q. Right.

5 A. I don't see anything that I disagree with. No, sir.

6 Q. Okay. Do you believe that there's a distinction
7 between the care given to inpatients as those that are
8 receiving treatments in the emergency department?

9 A. Do I think there's a distinction between inpatient
10 and ER? Yes, sir.

11 Q. And, in particular, the standard of care involving
12 the oxygen administration. Do you think that's different?
13 That's what I'm trying to figure out, Doc. Let me just--

14 A. Go ahead. Yes, sir.

15 Q. --rephrase this.

16 A. Yes, sir.

17 Q. In other words, we, at the hospital, have an
18 emergency department--

19 A. Yes, sir.

20 Q. --and we have admissions--

21 A. Yes, sir.

22 Q. --admitting patients.

23 A. Yes, sir.

24 Q. What I'm trying to figure out, do you administer
25 oxygen protocol differently in the emergency room than you

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1 do in the floor of the hospital?

2 A. I would have to see the two protocols to see if
3 their administration is different. ER is an acute place of
4 acute distress. Hospital inpatient can be not as acute,
5 but can still need it. Like this is talking about recovery
6 patients--

7 Q. Right.

8 A. --post-op patients.

9 Q. Right.

10 A. So they probably have different protocols, but I
11 have not seen them so I can't tell you what they are.

12 Q. Okay. Now, Doc, I don't know that you saw all of
13 the records from the Willis-Knighton Bossier. Do you
14 recall those?

15 A. Of the ER visit?

16 Q. Yeah.

17 A. Now, how would I-- I'm not real sure if I'd know if
18 I didn't see all of them.

19 Q. And that's what I want to talk about here just a
20 second.

21 A. Okay. Okay.

22 Q. Before we do that--

23 A. Yes, sir.

24 Q. --do you know what a SANE nurse is?

25 A. Yes, sir.

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1 Q. S-A-N-E?

2 A. Yes, sir.

3 Q. What is a SANE nurse?

4 A. In my mind, a SANE nurse is a nurse that comes out
5 and does sexual assaults, physical assaults. Any child
6 that is in--has any question of physical trauma, they call
7 a SANE nurse to do an exam on the patient, mainly, for--not
8 that another nurse can't do the exam, but it's for
9 medical/legal purposes.

10 Q. Would there be a report from the SANE nurse?

11 A. If they had a SANE exam, there should be. Yes, sir.

12 Q. And would that be in the medical files?

13 A. That, I do not know.

14 Q. Medical records. Do you ever call a SANE nurse?

15 A. Yes, sir.

16 Q. And did you make a report or did the SANE nurse make
17 the report?

18 A. Report to whom? We do a medical report when a
19 patient comes to the ER and the SANE does their report.
20 Now, do they do a separate report for the police? I do not
21 know. Was SANE called on this patient?

22 Q. Well, I was going to ask you about that.

23 A. Okay.

24 Q. Do you know anything about that, whether or not a
25 SANE nurse was called on this patient?

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1 A. I did not see that. Were they?

2 Q. I'll represent to you, Doctor, that on February the
3 10th--

4 A. Okay.

5 Q. --at 2:33 in the morning--

6 A. Okay.

7 Q. --that a GU exam--

8 A. Okay.

9 Q. --and tell the jury what we mean by GU exam.

10 A. Genital urinary exam.

11 Q. And I'll represent to you, Doctor, that that exam
12 had a negative finding for bleeding, swelling or discharge.

13 A. Okay.

14 Q. Would that indicate to you that there's any type of
15 abuse going on with this child?

16 A. That would indicate that there's no physical signs
17 in her GU exam which is just a--you can look and say those
18 things that you just said so that when they were doing
19 the-- I don't know if that was during the coding of the
20 patient or the evaluation when that was written.

21 Q. At the--

22 A. Is that on the physical exam when the patient came
23 back coding?

24 Q. This is on February the 10th at 2:33 in the morning.

25 A. That's on this ER visit, not when the patient came

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1 back. Is that right?

2 Q. Correct.

3 A. Okay. Okay. Yes, sir. So-- Right. There's no
4 physical findings.

5 Q. Yes, ma'am.

6 A. Yes, sir.

7 Q. Okay. I'll represent to you then at 3:52, the
8 patient was discharged from Willis-Knighton South and taken
9 to her grandmother.

10 A. Okay.

11 Q. I'll represent to you at 6:51, according to the
12 medical records--

13 A. Okay.

14 Q. --the family members witnessed respiratory arrest.

15 A. Okay.

16 Q. I'll represent to you that at 7:24, the patient
17 arrives at Willis-Knighton Bossier with no pulse.

18 A. Okay.

19 Q. I'll represent to you at 7:45, Dr. Horan who is the
20 physician in the emergency room at Willis-Knighton Bossier
21 who is receiving this patient that's coding--

22 A. Yes, sir.

23 Q. Okay. You with me?

24 A. Yes, sir.

25 Q. Dr. Horan.

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1 A. Okay.

2 Q. At 7:45, Dr. Horan calls Dr. Tran who was the--

3 A. Admitting--

4 Q. --emergency room physician who discharged the
5 patient.

6 A. Dr. Tran was not the emergency room doctor that
7 discharged the patient.

8 Q. Yeah. I think you're right. Dr. Tran worked on the
9 patient.

10 A. He's the PICU doctor. Dr. Tran is an inpatient
11 doctor. So I don't think Dr. Tran saw that patient that
12 morning.

13 Q. Really?

14 A. Dr. Easterling was the ER doctor that morning--

15 Q. Uh-huh (yes).

16 A. --and Dr. Tran is a hospitalist or a PICU doctor, if
17 I'm correct. I think there's a lady Dr. Tran and a male
18 Dr. Tran.

19 Q. Do you know either one of those doctors?

20 A. I know the names. I've met the man Dr. Tran one
21 time when he was working in the PICU.

22 Q. Dr. Tran works in the PICU where?

23 A. They're both at South. Dr. Tran.

24 Q. Okay.

25 A. The patient was seen at South on the first visit

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1 and, then presented to Bossier on the visit with the
2 coding. Is that right? Okay.

3 Q. What instance did you have to meet with Dr. Tran?

4 A. Approximately two, three years ago, I was at a
5 soccer game, watching my son play soccer in Bossier, and
6 one of the soccer players coded on the field and his
7 parents were not there. And so I went with him to Willis-
8 Knighton Bossier and then I rode with him to Willis-
9 Knighton South where the PICU was until the parents
10 arrived, and I met him there for fifteen, twenty minutes
11 till the parents got there and then I left.

12 Q. That's the same doctor we're talking about?

13 A. I don't know if this is--because I don't remember
14 seeing Dr. Tran on that second visit. That's the only Dr.
15 Tran I know. I do know that--I believe in some of these--
16 one or two of these admissions, there's a female Dr. Tran
17 that took care of him or it may have been him. I don't
18 know.

19 Q. Okay.

20 A. But I don't believe there's an ER doctor named Dr.
21 Tran.

22 Q. Okay. Thank you, Doctor.

23 A. Yes, sir. Yes, sir.

24 Q. Let me ask you. Have you ever inserted a catheter
25 in a four-year-old child?

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1 A. Yes, sir.

2 Q. What size of a French foley catheter did you use?

3 A. Oh, don't get my lying. Whatever the nurse handed
4 me. I mean, I couldn't tell you the appropriate size for a
5 child without looking.

6 Q. Would you take a look at what I'm going to mark--

7 A. Yes, sir.

8 Q. --just one second for-- And I need to let your
9 lawyers look at this just a second first.

10 A. Yes, sir.

11 **MR. BANKS:** I think we're at "Number 4."

12 Q. Okay. Doctor, could you take a minute and review
13 that and tell me whether or not, generally, you agree with
14 that? And I'll represent to you that it's a typical weight
15 and tube size for foley catheters broken down from six
16 months of age down to twelve months and respective size for
17 the--or twelve years, I'm sorry--six months to twelve years
18 and it's respective size foley catheters for those age
19 groups that's on the document there.

20 (Witness peruses document.)

21 A. Okay.

22 Q. Do you see anything that's out of line that-- Would
23 you agree with those?

24 A. Not offhand. Yes, sir.

25 Q. You would agree with that?

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1 A. I would agree with them.

2 Q. Okay. So if we have a child that's four years old,
3 what size catheter would be using?

4 A. It says between eight and ten.

5 Q. Now, if I understand right, and I don't profess to
6 know anything about catheters, but if I understand right,
7 there's a bulb at the end.

8 A. Yes, sir.

9 Q. And you have to inflate that bulb.

10 A. Yes, sir.

11 Q. And what size would you inflate for a four-year-old?

12 A. Well, the different foley site--the different foleys
13 have on the--have on the instrument or whatever, the
14 package, how much to inflate the bulb. But it's not
15 inflated until it's into the bladder. And anywhere from
16 five mils to ten mils to thirty, twenty mils and then to--I
17 mean, I don't know. I'm just giving you a hypothetical.
18 But it's on--it's on the catheter bag. So the-- And,
19 usually, sometimes in the catheter bag, the--there'll
20 already be a syringe of ten ccs of saline to put in the
21 bulb. Not always, but, oftentimes, that's even in there to
22 make it easier on the--on the nurse or whoever's putting in
23 the catheter.

24 Q. And it would be fair to say that there's a one-to-
25 one ratio between a milliliter and what's the other one?

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1 **MR. HUTTON BANKS:** CC.

2 Q. CC.

3 A. Yes. Yes.

4 Q. There's a one-to-one ratio.

5 A. Yes, sir.

6 Q. Okay. I'll represent to you that the child arrives
7 with no pulse at 7:24 at Bossier hospital, Willis-Knighton
8 Bossier and, at 7:45, Dr. Horan calls Dr. Tran and unable
9 to reach him or her, whichever.

10 A. Yes, sir.

11 Q. I'll represent to you that at 7:47, a nurse,
12 Stephanie Yeager, puts in--I'm not sure the word puts in--
13 puts in--

14 A. Right.

15 Q. --is the right word but--

16 A. Or in--

17 Q. Insert?

18 A. Right. Inserts. Yes.

19 Q. Inserts a--

20 A. I understand.

21 Q. --a French eight foley catheter.

22 A. Yes, sir.

23 Q. That's inflated to five ccs.

24 A. Yes, sir.

25 Q. And I'll represent to you that there's no assistance

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1 required for that.

2 A. She wrote on there no assistance? It's very hard to
3 put in a catheter on a four-year-old without assistance.

4 Q. Without assistance. And I may be wrong on that.

5 A. But if this-- Well, let me--let me go back.

6 Q. Sure.

7 A. An active four-year-old, it's very hard to put one
8 in. If this patient was obtunded or unresponsive, then it
9 was very easy to put one in on her own so--

10 Q. Now, the notation, "Patient tolerated well," what
11 would that mean to you?

12 A. It means she was--she didn't fight against you, she
13 didn't have any--she wasn't traumatized. She just,
14 unfortunately, I hate to be blunt, she just laid--she laid
15 there and-- It--it was without complications a lot of
16 times is that would be.

17 Q. Okay. Have we got to the brain dead part yet? Is
18 she brain dead at this point?

19 A. Well, I--I--you-- They haven't done an evaluation
20 for brain death at that time.

21 Q. So we don't really know?

22 A. Right. Yes, sir.

23 Q. But she's not moving?

24 A. Yes, sir. I would assume she didn't.

25 Q. Okay.

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1 A. If she laid there for a foley, yeah.

2 Q. If there were evidence of blood at the time that
3 foley eight catheter was inserted, would that be something
4 that the nurse would note or the doctor, whoever is putting
5 it in?

6 A. I would think the nurse put it in and you would
7 think she'd notice. Yes, sir. It's very-- You know, I'm
8 sure you've seen on TV-- I mean, codes are very crazy.
9 And so are you looking for evidence of trauma? Of course
10 not. You're just trying to insert a foley. But would it
11 be obvious right there on a four-year-old? It should be.

12 Q. Okay. Now, three minutes after Nurse Yeager inserts
13 the foley eight catheter, three minutes later, Dr. Horan
14 does talk to Dr. Tran.

15 A. Yes, sir.

16 Q. They do connect.

17 A. Okay.

18 Q. Okay. Thirteen minutes later, at 8:03--

19 A. Yes, sir.

20 Q. --Dr. Poole completes an order for a foley catheter.

21 A. Okay.

22 Q. Does that make any sense to you?

23 A. Sure. It does.

24 Q. What does that mean?

25 A. I mean, the order was put in three minutes later.

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1 When there's a code and there's a lot going on, verbal
2 orders are given, but they're not documented, and so it can
3 be put in a computer after the actual order was carried
4 out, and that often happens in codes. We do our best to
5 try not to do a procedure or any--take any order unless an
6 emergent situation so that documentation will not look like
7 that, but that does happen unfortunately in codes. And in
8 extreme circumstances.

9 Q. Okay. So let me recap just a little bit.

10 A. Yes, sir.

11 Q. The catheter goes in, a French eight at 7:47.

12 A. Okay.

13 Q. Three minutes later, Dr. Horan talks to Dr. Tran
14 and, at 8:43--

15 A. Okay.

16 Q. --there's a transfer that's ordered to Willis-
17 Knighton South.

18 A. Yes, sir.

19 Q. Do you remember seeing that?

20 A. Yes, sir. I mean, I didn't hone in on that follow-
21 up part. I'll be honest. But, yes, sir.

22 Q. Okay. Now, at 9:31--

23 A. Okay.

24 Q. --Dr. Horan notes a special discussion. Do you know
25 what special discussions are in terms of medical records?

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1 A. No, sir.

2 Q. Okay. And I don't either.

3 A. Yeah.

4 Q. That's the reason I'm asking.

5 A. No, sir.

6 Q. It just says special discussion.

7 A. Okay.

8 Q. I couldn't figure out what that was.

9 A. Who was he having the special discussion with?

10 Q. That's a good question.

11 A. Okay.

12 Q. I think it was Dr. Tran, but I don't know that.

13 A. Okay. Yes, sir.

14 Q. I don't want to represent that because I don't know.

15 A. Sure. Yes, sir.

16 Q. Okay. The special discussion is "the nursing staff
17 noted small amount of blood before placing the foley. The
18 blood apparently noted in the vaginal area."

19 A. Okay.

20 Q. Do you know any reason why that blood would not have
21 been noticed before 9:30 when the catheter was put in at
22 7:47?

23 A. You would have to ask that nurse and why she didn't
24 document it or she told someone and they said make sure and
25 document it. I really don't know, sir.

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1 Q. Now, at 9:50--

2 A. Yes, sir.

3 Q. --the child arrives at Willis-Knighton South--

4 A. Okay.

5 Q. --via ambulance.

6 A. Yes, sir.

7 Q. And Tran is at the bedside.

8 A. Okay.

9 Q. And the notes say that there's a size six French
10 foley catheter in place on arrival.

11 A. Okay.

12 Q. Do you know how we got from the eight size at 7:47
13 to the six size at 9:50?

14 A. I do not.

15 Q. Does that seem a little strange to you?

16 A. No. It's a lack of--it's documentation error.
17 There's--they clicked a button above or below, if I had to
18 guess. Or a nurse looked at it and it looked like a six
19 and she didn't--you have to get on it and look down to see
20 the actual six or eight. They're both small. They're very
21 small. So if I had to see--if I had to guess, she just
22 guessed on what it--she--size she thought it was.

23 Q. I gotcha. Now, if I'm understanding the series of
24 events here correctly, I would assume and that's an
25 assumption--

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1 A. Yes, sir.

2 Q. --I'll admit that to you. But I would assume that
3 when Dr. Horan talked to Dr. Tran at 7:50, they talked
4 about why did you send me this brain-dead patient. Why do
5 I have this brain-dead patient? You, Dr. Tran, she came
6 from your hospital, not my hospital.

7 A. Because Bossier does not admit pediatrics. So they
8 had to transfer to South where they take care of
9 pediatrics.

10 Q. Okay.

11 A. Yes, sir.

12 Q. Well, at 9:50--

13 A. Okay.

14 Q. --it's noted--the doctor notes--

15 A. Okay.

16 Q. --that there's skin tears to the vagina.

17 A. Okay.

18 Q. Do you know of any reason why that those skin tears
19 would not have been evidenced at 2:33 in the morning when
20 the GU exam was completed?

21 A. When the GU exam from the other ER visit?

22 Q. Yes. Right.

23 A. If I had to guess, a GU exam was not done. When
24 someone's in respiratory distress, I don't think they--or
25 it was done by a scrub. You'll have to ask them. But was

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1 a GU exam done? You'll have to ask them. If it's
2 documented, sometimes, it's a cursory, and it's looking--
3 To look into the vagina of a child, you have to spread
4 their legs and look. Can you look without spreading them?
5 You can look but you're not going to get a very adequate
6 exam. Do I look at a GU exam on a child with asthma
7 exacerbation? I do not.

8 Q. What is ROS?

9 A. Review of systems?

10 Q. Thank you.

11 A. I'm sorry.

12 Q. Thank you. If an ROS is documented at 2:33 in the
13 morning, there was a GU exam, would that lead you to
14 believe that there was, in fact, a GU exam?

15 A. The review of systems is verbally. You're asking
16 them the review of systems. Only on the physical exam
17 under GU would you note that they visually looked at it.
18 But under review of systems, you're just asking do you have
19 any bleeding, do you have any tear, do you have any
20 contusions, and they're just saying. Does that make sense?
21 The review is just asking--is asking the patient have you
22 been short of breath, have you had chest pain, has the baby
23 had belly pain, had they been nausea or vomiting.

24 Q. How would we know at 2:30 in the morning that it was
25 negative for bleeding, the exam was negative for bleeding

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1 or swelling unless there was an actual exam done?

2 A. Right.

3 Q. So would you agree with me that if it's noted as an
4 exam, GU exam, with no bleeding and no swelling, that that,
5 in fact, was done, that exam was done?

6 A. You have to assume it was done. Yes, sir.

7 Q. Okay. My question to you is if we did this exam at
8 2:33 in the morning--

9 A. Yes, sir.

10 Q. --and at 9:50, this child is noted to have skin
11 tears to the vagina, could you explain that?

12 A. No. And that's probably why they got a SANE nurse
13 to look at it. You have to be super, super--have a very
14 low threshold so that you don't miss any children. It's a
15 mandatory obligation that you have to call them. So even
16 if you don't necessarily think there's something, if it's
17 documented, or there's any concern by any staff, they will
18 be notified. So were they flamboyant? I mean, I'm saying
19 about trying to see was this child molested, injured in any
20 way. Even when we think it's not, and it's documented or
21 questioned or wondered, we're going to report it just for
22 the sake of the safety.

23 Q. And, in fact, that's what happened. The house
24 supervisor, I'll represent to you, at 9:50, called the
25 Shreveport Police Department and the Child Protective

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1 Service. So would you assume that if those calls were made
2 by the SANE nurse to the Shreveport Police and the Child
3 Protective Service, that at least the person who made the
4 call, the house supervisor in this case, very much
5 suspected that there was abuse going on?

6 A. She didn't necessarily suspect, but if there's any
7 signs or symptoms or any story, you're mandated to--to
8 call.

9 Q. Now, you would agree with me that the only place
10 this child has been since 2:33 and 9:50 is two places.
11 She's been at the Willis-Knighton South hospital in this
12 interval. Right?

13 A. Yes, sir.

14 Q. And she's been to grandma's.

15 A. Yes, sir.

16 Q. Okay. So if we're talking about abuse, either
17 grandma knows something about it, or the hospital knows
18 something about it. Right?

19 A. Uh-huh (yes). Yes, sir.

20 Q. Now, at 10:00, ten minutes later--

21 A. Yes, sir.

22 Q. --after they call the police--

23 A. Yes, sir.

24 Q. --ten minutes later, it's noted that there's a
25 twelve sized French foley catheter. Could you explain

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1 that?

2 A. No, sir.

3 Q. Could you explain at 10:00, how one would note that
4 there are tears to the vagina wall that looked fresh, two
5 to three tears that are noted, when, in fact, the GU exam
6 at 2:33 was negative for bleeding and swelling? Could you
7 explain that?

8 A. The only explanation is that someone brought it to
9 the attention of the provider and he looked down there and
10 then documented it. In a code, that's the last thing he's
11 worried about, but when a nurse sees that, when they're
12 putting in a foley, they're obligated to tell.

13 Q. And that's kind of what I want to talk to you about.
14 It's a code situation. Right?

15 A. Yes, sir.

16 Q. And Dr. Tran realizes that this patient that was
17 formerly at Willis-Knighton South--

18 A. Yes, sir.

19 Q. --went to grandma's and then went to the ambulance,
20 coded back to Willis-Knighton--

21 A. Bossier.

22 Q. --Bossier and, now, he's--Dr. Tran is back on site
23 there as the attending physician, pediatric physician?

24 A. He's the--he's a PICU attending. The pediatric
25 intensive care at Willis-Knighton South.

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1 Q. Okay. Do you know what the very first thing he sees
2 at 10:00 on this patient that's coded?

3 A. Is what?

4 Q. Tears to the vagina wall that looked fresh.

5 A. The first thing he documented?

6 Q. One of the first.

7 A. I didn't see the--I haven't seen that chart.

8 Q. Okay. Is a size twelve French catheter too large
9 for a four-year-old female?

10 A. It is large for the--according to this, yes, sir.

11 Q. Well, if the family committed the abuse, it had to
12 happen after the child was discharged from Willis-Knighton
13 South and taken to grandma's house. Would you agree with
14 that?

15 A. Then or they didn't do a good physical initially and
16 it was done sometime during the night prior to the other
17 visit. I mean, it could've happened at any time. You have
18 a normal thing, but you're going to have to ask the
19 provider when he wrote it, how well did you look-- I mean,
20 he's--he's not going to spread her labia and look down
21 there on a child with asthma.

22 Q. Unless he wants to have that particularly noted in
23 the medical records. Right?

24 A. It's not particularly noted. It just says GU,
25 normal, no edema-- You can see no bleeding without

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1 touching and spreading the child's legs, if I'm--

2 Q. So you're thinking--

3 A. --to be crude.

4 Q. --back at 2:30 in the morning when the GU exam was
5 done, that they just really missed it. Is that what--

6 A. I won't say they missed it. But I don't think they
7 did a very thorough look of it, but you would have to ask
8 them.

9 Q. Okay. Do you see anything particularly disturbing
10 about this situation where Horan, who receives a coded
11 patient, he did not see the blood, he did not call CPS, he
12 did not call the Shreveport Police Department, he didn't
13 call the SANE nurse? But Horan takes it upon himself, he
14 says that the nurses noted blood before the catheter was
15 placed.

16 A. Yes, sir.

17 Q. Does that make any sense to you?

18 A. Yes. It does.

19 Q. Explain what you're thinking.

20 A. It's not--it's not the-- The protocol has either
21 the charge nurse or the house supervisor that notifies the
22 police. The doctor, that's not part of their protocol for
23 doing that. If the patient would've come in with possible
24 sexual abuse and that would be what the doctor was focusing
25 on-- This is a--this is a four-year-old child that is in

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1 respiratory arrest, possibly dead at this time. That is
2 the last thing the ER doctor's focusing on.

3 Q. That's the--

4 A. The only reason the doctor looked at it was because
5 the nurse, when putting in the catheter, noticed this. So
6 he's mandated to document this.

7 Q. Here's my situation.

8 A. Yes, sir.

9 Q. Here's what I'm really struggling with.

10 A. Okay.

11 Q. Where's the notation from the nurse that there's
12 blood before the catheter?

13 A. Well, I don't know. You'll have to ask them.

14 Q. Did you see any such in your review?

15 A. I did not review that in detail. No, sir.

16 Q. Okay. If I represent to you and, hypothetically, I
17 am representing to you, a situation where there's no blood
18 that's ever noted in any medical record before the catheter
19 is inserted, could you explain with that situation and
20 given what I've represented to you--

21 A. Can I explain it? If it's--if it's a foley catheter
22 insertion and it's already printed and you hit a button and
23 it goes out and says no complications, nothing, and then
24 she mentions it and says I did see some blood, and the
25 nurse says, did you document it, that's important, we need

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1 to know, even though it's a code, she's going to go back in
2 the chart and document that. So why would she document it
3 against herself is because she's noting it. I mean, I
4 don't know if it's the same nurse or a different nurse.
5 That, unfortunately, happens with these electronic medical
6 records. And this is kind of something that's coming after
7 a code. They're not worried-- Unfortunately, they're not
8 thinking that this chart's going to a lawyer and that we
9 need to make sure nothing doesn't--

10 Q. Do you know who was reported for abuse?

11 A. Do I know who? No, sir. I didn't--I didn't see any
12 of that.

13 Q. Do you know who was investigated for abuse?

14 A. They investigate the parents and the grandparents or
15 whoever lives with them. They do a pretty thorough
16 investigation.

17 Q. Okay. So if the GU exam that's noted in the
18 records--

19 A. Uh-huh (yes).

20 Q. --was done correctly--

21 A. Right.

22 Q. --noting that there is negative bleeding and
23 negative swelling--

24 A. So really-- Did a SANE nurse come and do an
25 evaluation on this child?

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1 Q. I don't know.

2 A. Okay. I mean, really, all this negates anything if
3 you have a SANE evaluation. And I guess in the inpatient
4 side of that chart, it may say whether they decided to
5 pursue it or did not or I don't know. But whether there's
6 inconsistencies there, if a SANE has an evaluation, that's
7 going to tell you if they think there's any trauma or could
8 it have been from the foley catheter insertion from the--
9 the craziness in the ER of putting it in? That skin's very
10 friable. It could've easily, you know, could it have
11 happened? Absolutely.

12 Q. On February the 12th--

13 A. Yes, sir.

14 Q. --two days later--

15 A. Yes, sir.

16 Q. --the size twelve French catheter is in place.

17 Again, I'll ask you the same question that we've talked
18 about. Do you know how we go from the eight size to the
19 six size to the twelve size?

20 A. No, sir.

21 Q. On February the 13th, I think we're talking about a
22 brain-dead child at this point. Are we, Doc?

23 A. I did not review that chart.

24 Q. Okay.

25 A. I'm sorry.

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1 Q. No. No problem. On February the 13th, at 5:50
2 p.m., it's noted a large area of swelling is noted to the
3 pubic mound region in the labia, more so the pubic mound.

4 A. Okay.

5 Q. How long would it take for that swelling to appear?

6 A. From trauma?

7 Q. Right.

8 A. From abuse?

9 Q. Right.

10 A. From a couple of minutes to a couple of hours. Was
11 there bruising with it? Was there just swelling? I think
12 without a SANE exam or a SANE thing, I don't think it's
13 really worrisome about any of this. If the child's been on
14 fluids and all that, they could be having swelling
15 anywhere. Because the swelling from the trauma of putting
16 a catheter in very rapidly, is it from sexual abuse?

17 Q. Well, it's very concerning to me, Doc, that swelling
18 would happen in a couple of hours.

19 A. Uh-huh (yes).

20 Q. Do I have that right?

21 A. That it can happen in a couple of hours? Sure.

22 Q. I mean, well, do it this way. More likely than not,
23 how long is it going to take for that swelling to appear on
24 the pubic mound?

25 A. It can be within a couple of minutes to a couple of

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1 hours.

2 Q. Okay. We're on February--

3 A. But we're a couple of days out. Right?

4 Q. Right. Could you explain that?

5 A. No. I can't.

6 Q. On February the 14th there's a notation at 4:12 in
7 the morning, that we're going to remove the twelve size
8 foley catheter and we're going to substitute a ten size
9 foley catheter and we're going to reduce the bulb from five
10 milliliters to three milliliters. And if I'm figuring
11 right, that's about a forty percent reduction.

12 A. Okay.

13 Q. Tell me what's going on in the medical community
14 when they're doing this.

15 A. Well, you'd really have to ask them. But let me
16 just tell you my thought, but I don't feel like-- Okay.
17 So when there's blood, if the blood's from urine, like you
18 say you have hematuria, hematuria--any small amount of
19 blood can cause clots and then you can't urinate. So you
20 do typically put a large--larger foley in a patient to keep
21 the flow of it. And so with the larger foley so it's--
22 The whole reason of putting the bulb is inside the bladder,
23 it's keeping it from pulled out. So if he put a smaller
24 foley, then it's not unlikely that the bulb is smaller.
25 But the bulb is inside the--inside the bladder. So it's a

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1 forty percent, but it's--we're talking two ccs, you know
2 what I'm saying? It's--it's not that much difference. But
3 it's just keeping the--the catheter from being pulled out
4 of the child. That's just to hold it in place. So I don't
5 know why they changed it to a twelve, but that's--my guess
6 would be because maybe they saw blood and they weren't sure
7 if the blood was from the--from the bladder or not. I
8 don't know.

9 Q. Do you attach any significance or find it in the
10 least bit odd that it's Dr. Tran who's noticing the
11 problems here with the abuse?

12 A. No. Dr. Tran is a PICU doctor. Once that-- Their
13 whole thing is the entire patient. Not only--and they--and
14 they are liable and they're mandated, and it is just
15 pounded into us that if there's any question, it has to be
16 reported, especially in pediatrics, especially. So,
17 probably, unfortunately, they--I won't say they're experts
18 at it, but they see it more so than the average physician.

19 Q. Okay. Doctor, the testimony that you've given here
20 this afternoon, do you feel like that's supported by a
21 timeline?

22 A. To a-- Supported by the timeline of the child's
23 life or the timeline--

24 Q. Facts. Facts within the initial--

25 A. The ER visit?

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1 Q. --the initial ER visit until they pulled the plug on
2 the child. Do you feel like your testimony is consistent
3 with the timeline of facts in that time period?

4 A. Yes, sir.

5 Q. Okay. And would you agree with me that if you have
6 some of your facts wrong, that it would give its sway to
7 some of the opinion that you have? In other words, there
8 would be something less than desired about the opinion,
9 it's not exactly accurately, if we're not dealing with the
10 same facts?

11 A. If my facts were wrong?

12 Q. Right.

13 MR. ROBISON: Object to the form.

14 A. I guess if anybody's facts were wrong, that my
15 opinion would be different. Yes, sir.

16 MR. BANKS: I think that's all we have, Doctor.

17 WITNESS: Okay.

18 MR. BANKS: You have the right to read this and
19 sign it or you can waive that right, whichever
20 you prefer.

21 WITNESS: I'd like to read it, if that's okay.

22 MR. BANKS: Sure.

23 (OFF RECORD)

24 MR. BANKS: Doctor, what I'd like for you to do
25 is would you make a copy--

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1 **WITNESS:** Of any of these?
2 **MR. BANKS:** --of your notes here.
3 **WITNESS:** Absolutely.
4 **MR. BANKS:** And attach that to your deposition
5 collectively as " White 5."
6 **WITNESS:** Absolutely, yes, sir.
7 **MR. BANKS:** And, then, Doctor, one more thing I
8 need.
9 **WITNESS:** Yes, sir.
10 **MR. BANKS:** In addition to your notes from--
11 **WITNESS:** Well, I don't even know which one's
12 the first one. I'm sorry. If I'd have known,
13 I would've done it neater. You can put it
14 right here, if you want.
15 **MR. BANKS:** Okay. Let's call that "White 5."
16 I'm sorry. Thank you.
17 **WITNESS:** So you want me to make copies of all
18 these? Like, these are the ER visits, anything
19 that I wrote?
20 **MR. HUTTON BANKS:** In globo?
21 **MR. BANKS:** In globo. Right. Everything in
22 your file?
23 **WITNESS:** Yes, sir.
24 **MR. BANKS:** And the last thing what I need--
25 **WITNESS:** Yes, sir.

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1 **MR. BANKS:** --is that initial opinion that you
2 wrote.

3 **WITNESS:** Yes, sir.

4 **MR. BANKS:** The very first one. Let's do that
5 as-- Well, we can do it as in globo and, put
6 it in "5." Just have one exhibit.

7 **WITNESS:** Yes, sir.

8 **MR. BANKS:** All right?

9 **WITNESS:** Okay.

10 **MR. BANKS:** And that's all I've got.

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(DEPOSITION CONCLUDED)